00	46	9
----	----	---

910	EKHILICATE OF DEATH					
1, PLACE OF DEATH 2. USUAL RESIDENCE (WH	here deceased li		oni Residence	e before adi	nission)	
o. COUNTY Carroll Maryland O. STATE Maryl	and	b. COUNTY	Balte	o. Cit	v	
b. CITY OR TOWN (If autide carporate limits, write   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (If a		limits, write Rt	JRAL ond gi	ve nearest f	own) v	
Springfield State Hospital 8mos. 29days Balti	more		,3	101.	4	
d. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION  d. STREET ADDRESS					RESIDENCE	
Sykesville, Maryland 1011	W. 38th	St.		YES	□ NO√2	
3. NAME OF First Middle Last DECEASED	4. DATE	Mont		Day	Year	
(Type or print) Mary Merson ADELSPERGER	DEATH	Janu		7,	19 58	
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH	2.000	AGE (In years last birthday)		YEAR IF U	rs Min.	
Female White WIDOWED DIVORCED August 26,						
100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State during most of working life, even if retired)		try)			AT COUNTRY	
Housewife — Marylan  13. FATHER'S NAME 14. MOTHER'S MAIDEN N			U,	S.A.		
		3				
George Merson Julia W  15. WAS DECEASED EVER IN U. S. ARMED FORCES? 14 SOCIAL SECURITY NO. 117. INFORMANT	nitenea	Cl. Addr				
[Yes, no. or unknown] [ (If yes, give wor or dates of service]	3.3 W					
	Ta nosp	ITAL ME	coras			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:				ONSET A	BETWEEN ND DEATH	
IMMEDIATE CAUSE (0) UTEMLE				2 da	<b>y</b> 3	
443X DUE TO				35		
Conditions, if ony, which (b) Hypertensive cardiovascular d	1sease			Year	8	
couse (a), stating the under-						
/ (0)	NAI DISEASE C	ONDITION GIV	FN IN PART	1(a) 19. W	YZYOTUA ZA	
C.B.S. associated with circ.dist., with cerebral ar	teriosc	lerosis	, with	PEI	FORMED?	
				163	المرات ال	
5 psychotic reaction.  20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in	Part f ar Part II	of item 18.)				
C.B.S. associated with circ. dist., with cerebral ar psychotic reaction.  20a. ACCIDENT WAS UNDERLYING []   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in life (if Either, Notify Medical Examines)	Part f ar Part II	of item 18.)				
			(Co	ounivi	(State)	
	n,   20f. (City ar		(Cc	ounly)	(State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.  19 While Not while of work at wark 19 declary, street, effice bldg., etc	n, 20f, (City or	fawn)				
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of work at work 21. I certify that I attended the deceased from April 8, 197, ta Ja	n. 20f. (City or	town)	,,that I is	ast saw tl	ne decease	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of wor	n. 20% (City or	town)  9 , 19 58 he causes a	"that I lo	ast saw tl	ne decease	
20c. TIME OF INJURY Month, Day, Year While Not while of work o	n. 20% (City or PM, from I	town)  9 , 19 58  the causes at city or town,	"that I lo	ast saw tl	ne decease	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of wor	n. 20% (City or PM, from I	town)  9 , 19 58  the causes at city or town,	"that I lo	ast saw tl	ne decease	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of w	n. 20% (City or muary 7 P.M., from the Address (Street, eld Sta	town)  9 , 19 58 the causes a the city or town, te Hosp	"that I lo	ast saw tl	ne decease	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of w	nuary 7 PM, from I ADDRESS (Stree- eld Sta	town)  9 , 19 58 the causes a the city or town, te Hosp	"that I ic ind an the state) ital	ast saw the date st	ne decease	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of while of work of wo	nuary 7 PM, from I ADDRESS (Stree- eld Sta	town)  1958 he causes and city or town, te Hosp yland	"that I ic ind an the state) ital	ast saw the date st	ne decease ated abave DATE SIGNEI /7/58	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While of work of while of work of wo	nuary 7 PM, from I ADDRESS (Stree- eld Sta	town)  1958 he causes a st. city or town, te Hosp yland N (City, town, a	"that I ic ind an the state) ital	ast saw the date st	ne decease ated abave DATE SIGNEI /7/58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 TO FU VS A15 (4) 15M 9/55

moy be

retained by the nospirol or attending processing by the ottending physician and completely.

AL DIRECTOR: After this certificate has been signed by the ottending physician and completely. Po

retained by the haspital ar attending physician.

pages. Thould be detached for use as the burial-transit permit. Then please remove carbon papers. the registrar prior to burial, cremation, or removal, and in any event within 72 haurs after death.

d in by the funeral director, I and 2 should be filed with

CHUNNICATE OF DEATH

Burning to Brist

BUREAU V. S.

8361 OT NA!

BECENAED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MIRICATE OF DEATH

BUREAU V. S.

szer a Mal

BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Reg. Dist. No. e. 15 RESIDENCE ON A FARM? YES NO Day Year IF UNDER I YEAR IF UNDER 24 HRS Hours Min. 12. CITIZEN OF WHAT COUNTRY? INTERVAL BETWEEN ONSET AND DEATH noun

YES NOW

(County)

(Slote)

ADDRESS (Street, city or town, stote)

Months

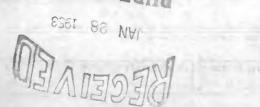
Days

246. REGISTRAR'S SIGNATURE

VS A15 (4) 15M 9/55

CERTIFICATE OF DEATH





TO DEPUTY MEDICAL EXAMINER: This certificate should be

TO FU VS. A15ME 5M 2/57

00472 Reg. Dist. No.

		~~~~				THE PARTY OF THE P			-		-			
1. PLACE OF DEATH	773			44450141	11 0	SUAL RESIDENCE (	_	sed lived. If institu	Y		_			
	Carroll foulside corporate limits, write	PUPAS	c IFNGT	MARYLAN H OF STAY IN 1		Maryland Carroll								
and Size centers tome	1]	e nunne							NORAL OF	ia Bisa i	legrest town			
Sykesvi:	AL OR INSTITUTION (	f not in		.18days		STREET ADDRESS	inster	*		-	e. IS RESIDENCE			
	ld State Ho			rider oddress)	1	m m					ON A FARM?			
3. NAME OF DECEASED (Type or print)	Fir Min		Amar	Middle	Lee	BEAVER	4. DATE OF DEATH	Janua		Doy				
5. SEX Female	6. COLOR OR RACE White			ER MARRIED		of BIRTH	886	9. AGE (In years lost birthday) 71 yes.	IF UNDER	R 1YEAR Doys	Hours Min.			
10a. USUAL OCCUPATION during most of working to USEWI	ON (Give kind of work to life, even if retired)	done 10	b. KIND OF BU	SINESS OR INDI	1		e or foreign o	1	12. CI		S.A.			
13. FATHER'S NAME Levi Lee					14. M	Annie Ha				100				
15. WAS DECEASED EV	ER IN U. S. ARMED FO		16. SOCIAL SEC 215-14		INFORM ST	ant oringfiel	d Hosp	Address ital Rec						
	diate cause		ine for (o), (b), Pulmona	-	lism					ONS	ET AND DEATH			
E U.D. D. 388	HER SIGNIFICANT CON BOC. WITH di disease wit USE WAS NTRIBUTING D	St. C	or metan	creacti	rowt	ATED TO THE TERM  OF NUTE  Here of injury in Po	ition,	with sen	ile		9. WAS AUTOPSY PERFORMED? YES NO			
20c, TIME OF INJUI	RY Month, Day, Yes	W	od. INJURY OCC	while	LACE OF actory, stre	INJURY (Home, former, office bldg., etc.	m, 201, (City	( or lown)	(Co	ounty)	(State)			
	nat I taak charge resulted fram: I		causes [	. Acciden	- 0			_		- transmit				
ACTUAL	James .	2	The	ack	MI	CHIEF MEDICAL E	XAMINER [				DATE SIGNED			
	James T. Ma	rsh,				ASSISTANT MEDICAL		_			1/15/58			
220. BURIAL, CREMATIO REMOVAL IS PROTY! BURIAL	1-18-58			OF CEMETERY T	Bre	thran	1	TION (City, town, roll Co			(Stote)			
23. FUNERAL DIRECTOR	S SIGNATURE Waltz,	Wir	nfield,	SS			'D BY REGIST				RE			

40dg. to store, & 1216.

BUREAU V. S.

8361 AT NV!

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DE ARTMINET DE HEALTH-EACHMORE, 18

MARKET.

office and the second

MATERIAL PROPERTY.

10 miles (1984)

BUREAU V. S

8561 4 NYI

BECEINED

death.

within 24

certificate

O HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



BUREAU V. &

1	,		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
	7.		482 CERTIFICATE OF DEATH Reg. Dist. No.
Poge director	(	1	PLACE OF DEATH  O. COUNTY ARROLL  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  O. STATE  MARYLAND  D. COUNTY CARROLL  MARYLAND
eoth.			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  RURAL and give nearest town)
urs after d by the fur d 2 shauld	AT	) [	d. NAME OF HOSPITAL (If not in hospital, give street address)  or Institution
24 hot		3.	NAME OF DECEASED Middle BOWERS OX 4. DATE Month Day Year OF DECEASED (Type or print) MARGIE VIOLA BOWERS OX 9 1958
within Pog	,	5.	SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH   9 AGE (In years left UNDER 1 YEAR IF UNDER 24 HRS. lost birthday)   Months   Doys   Hours   Min
omple opers.	(I	10	WIDOWED COUNTRY?  On USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country)  12 CITIZEN OF WHAT COUNTRY?  13 CITIZEN OF WHAT COUNTRY?
ond cor	-	1,	Howard It Mother's MAIDEN NAME
ote briccion e cork		1,3	JOHN W. BLACK LEE ANNA FOUTZ
physicemov physicemov physicemov			WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT  EN TO OF UPRODUM)  Address PENNA. A VE.  Address PENNA. A VE.  TO OF UPRODUM)  ADDRESS TO A PENNA CICAR TO THE PRODUCTION OF THE PR
anding eose thin 7		-	18. CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c).]
the de office of the plant with wind with the plant			PART I. DEATH WAS CAUSED BY: Cacaray Thrankson ONSET AND DRATH
that by the lift. The eve			Conditions, if ony, which) the stay of the C. Ululy of the
quires signed perm d in o			gove rise to immediate cosse (a), stating the under lying cause lost.  (c) (c) Karia Sefancia (c) (d) Karia Sefancia (d) Syrva
ow re sician been s fransil		NO	
The I g phy hos I eriol-	C	FICAT	YES NO
tendin ficate the b		CERT	OR CONTRIBUTING (I) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSIC lol or at this cert ir use as		MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o. m. p. m. 19   While   Not while at work   Ol work
hospil After hed for			21. I certify that I attended the deceased from the control of the saw the deceased
TOR: detact			alive an 190 / pind that death accurred at 1 M, from the causes and an the date stated above.  ADDRESS (Street, city or town flote)  DATE SIGNED
OR / ined b DIREC Id be prior	. /		SIGNATURE WYCECON DECEMBER WISHMING MAY 1/11/58
reto Thou			PHYSICIAN'S NAME (Type)
FUY Page 2	,	77	Co. BURIAL, CRÉMATION, 22b. DATE THEREOF  22c. NAME OF CEMETERY OR CREMATORY  22d. LOCATION (City, town, or county)  27d. LOCATION (City, town, or county)  27d. LOCATION (City, town, or county)  27d. LOCATION (City, town, or county)
VS A15 (4) 15M 9/55		23	FUNERAL DIRECTOR'S SIGNATURE  CONCIL CO 13 CHICAGO AND A SIGNATURE  CONCIL CO 15 CHICAGO AND A 1 4 158 CONTRACTOR AND A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
13W 7/33			Office of the second of the se

BUREAU V. E.

edit it MA!

BECEINED

0

SOUL OF MAI

58 BUREAU V. S.

56 Jan. 7

Apr. 27

58 January 6

..., with cerebral arteriosclerosis, with psychotic reaction.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

& . V UATRUA

OBAISON!

DATE AN 1 3

within 24 haurs after death.

executed

requires that

2 .V UAIRUA

DECEIVED SI NAU

				I	
Н	F	O	R LT	S1 H	ľ.
is certificate should be executed within 24 hours after death. If any delay is necessary, please	word "pending" in pencil in Hem, 18. Give Pages 1, 2, and 3 to the funeral director. Page	Chief Medical Examiner's Office along with form PM3. Page 5 may by signed for your files.	3 should be used as a burial-transit permit. File pages 1 and 2 with Walare Board of Health, 📆 😿	r to barial, cremation, ar remayal, and in any event within 22 hours after death.	(
AMINE	e, writing the	led to the	Page 2	, prior	
Y MEDICAL EXAMINER: Th	ertificate, 1	warded	ECTOR:	d agent	
L MEDI	he certi	be for	AL DIR	signate	
FPUT	cute t	The state of the s	5	fs des	

FOR S	* STATE			MEDICAL EXAMINER'S CERTIFICATE OF DEATH  Reg. Dist. No. 10 (1479)
	H DEP	_		
0.0 2			1.	TACE OF DEATH  2. USUAL RESIDENCE (Where deceased I'ved. If institution. Residence before odm.ssion)  5. COUNTY  9. STATE 31.7. ( / A \ b COUNTY 3.2.7 / A \ county 3.2.7 / A / A \ county 3.2.7 / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A / A /
Pog es.	1 "	, \	<u> </u>	MARYLAND 1//// YZ///Y
大き	( B		, ,	c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town)
of to go	1	1	16	THE NEW WINDSOR MONTHS LIVERAL NEW WINDSOR
ord ord				I. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)   d STREET ADDRESS   e IS RES DINCE
2 TO DO				ON A FARM?
oy or	Ę		3,	NAME OF First Middle Lost 4. DATE Month Doy Year
O P	ď			DECEASED PATRICE ANN BUTLER DEATH TAN 1 1958
P S	<u> </u>		5. 5	TIVE NOTE OF IN
= B	2			Part supposes The supposes The state of the
\$ 2 m c	2/2	1	30-	7
deo 2, o	N A	,	5	USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country)  12 CIT ZEN OF WHAT COUNTRY?  13 CIT ZEN OF WHAT COUNTRY?
P :	£ 2	1	_	ACNE NONE MONE WASH
Ses Ges	<b>1</b>		13.	FATHER'S NAME  14. MOTHER'S MAIDEN NAME
Pa Pa	en en			CHARLES IVM BUTLER   LOUISE BUTLEK
forr File	5			WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address RURAL LITTY OF WOLD OF BOLIES OF SERVICE STATE OF THE PROPERTY OF THE PR
E	E C			NO NONE LOUISE BUTLER NEW WINDSOR DAD
TE SE	.5			18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
P E O	6			PART I. DEATH WAS CAUSED BY: MEUTE BRONCHO PRELLMONIA HOUS
Ba e E	<u>6</u>			MAMEDIATE CAUSE (6) UE UFZ DRONCHO PREUMONIA HOUS
81-15 F	Š			Conditions, if ony, which)
To be a	ē			gove rise to immediate couse
in and	ō			(c), stating the underlying DUETO
E S	5		2	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY
ed age	Ë		2	PERFORMED?
per	ě	^>	5	YES NO
P de	<u>,</u>		CERTI	206. EXTERNAL CAUSE WAS PRIMARY ( or CONTRIBUTING )
2 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	700			CAUSE OF DRATH.
유민	0		MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 120f (City or town) (County) (Slate) factory, street, office bldg., etc.)
NE Pe 3	5		¥	p. m. 19 of work of work
A.M.	۵			21. I certify High I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my
Ed.	te ent			opinion death resulted from. Natural couses . Actident . Suicide . Homicide . Undetermined manner
AL	0			1 1 4 1
DIC NEW YORK	ē			SIGNATURE STEELERS . PROTESTIONED M.D. CHIEF MEDICAL EXAMINER []
ME CO	e			ASSISTANT MEDICAL EXAMINER
> = = ₹	S S			NAME ITYGEN TO MES I MORSH DEPUTY MEDICAL EXAMINER TO
A STATE		(	220	THE THE PORTAL CREMATION 226 DATE THEREOF 22C. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stote)
0 5 4	ò			REMOVAL (Specify) 1/3/58 WESTERN CHAPEL CARPALL CLI RIX
5 5			23.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS LAW REGISTRAR 246 REGISTRAR 246 REGISTRAR'S SIGNATURE
VS A1SME			1	ON That they day of Marce Illiand and Mark of C 10ER 1 116
5M 2/S7			LA:	o may we have the walkers many to 1000 1 1/18 and

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

SAMILIAN STATE

attending

څ

0

₽.

E 'A C.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

S'A I''

1 .		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
. ( N		489 CERTIFICATE OF DEATH Rog, Dist. No. U () 482
directo	7	1. PLACE OF DEATH O COUNTY  CARROLL  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) O STATE MARYLAND  b. COUNTY
funeral		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)  STESVILLE  STANS  BALTIMORE  BALTIMORE
by the	6	d. NAME OF HOSPITAL (IF not in hospital), give street oddress)  SPRINGFIELD STATE HOSPITAL 504 GILMORE ST.  VES NO PROPERTY.
12 in		3. NAME OF DECEASED (Type or print) George Raymond CHANEY DEATH Jan 22 1958
Pletely Pars. Pa		5. SEX    6. COLOR OR RACE   7 MARRIED   NEVER MARRIED   8. DATE OF BIRTH   9. AGE (In years lost birthdoy)   Months   Doys   Hours   Min   Doys   Min
on pope deoth.	, L	100 USUAL OCCUPATION (Give kind of work done done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country)  WONE  12. CITIZEN OF WHAT COUNTRY?  WARYLAIN  15. A
sicion o ve carb ars after		CHARLES B. CHANEY MARY E. BOYCE
ing phy re remo 72 hau		15. WAS DECEASED EVER IN U. S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Records of SPRINGFIELD MOSPITAL
attend en pleas It within		18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (o) CEREBRAL HAEIMBRAGE  INTERVAL BETWEEN ONSET AND DEATH DAY
gned by the permit. The in any even		Conditions, if any, which gove rise to immediate couse (a), stating the under OUE TO  DUE TO GENERACIZED ARTERIOSCLEROSIS MORE THAN  OUE TO
been si transit al, and		Iying couse lost.   (c)
cale has se burial		PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONTRIBUTION TO THE TERMINAL DISEASE CONDITION IN PART 1(0)  PAM II. OTHER SIGNIFICANT CONTRIBUTION TO THE TERMINAL DISEASE CONDITION
his certific use as the		20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour o.m. 19 While of work of
ched far		21. I certify that I attended the deceased from MARCH, 1956, to Four 20, 1958 that I last saw the deceased alive on Jan 20, 1958, and that death occurred at 4:4 PM, from the causes and on the date stated above.
RECTOR be deta riar to b		ACTUAL Walth Kuon M.D. SPRINGFIELD STATE HOLP. 1-22-
hauld istror p		PHYSICIAN'S WALTER KNOPP Sykesville MARYLAND
Pogether reg		220 BURIAL CREMATION, 72%. DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d LOCATION (City, town, or county) Manylans
A15 (4) M 9/55	[	23. FUNGERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS  ADDRESS  ADDRESS  DATEJAN 2 7 '58  OUT EDILLE  ADDRESS  AD
4.		

## 2 . Y. UARRULY.

ान्य । व्याप्त विकास के प्रति । विकास के प

filed

pe

O V E

ā

8

O FU

**VS A1S [4]** 

1SM 9/SS

the fund

deoth.

offer

TA ATTIMA

4 NVI

1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
FOR STATE	49 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 00484
IEALTH DINT.	1. PLACE OF DEATH o. COUNTY /2  o. STATE b. COUNTY
Files Health	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and give pagget town)  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
your d of	d. NAME OF HOSPITAL OR INSTITUTION (I not in hospital, give street address) d. STREET ADDRESS e is RELIDEN E
P. Boo of	YES NOTE NOTE NOTE NOTE NOTE NOTE NOTE NOTE
Sept.	3. NAME OF DECEASED (Type or print) GEORGE ELLSWORTH COURT DEATH Jaw 26 1958
the state of the s	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 99. AGE III years lext burthday! Months Days Hours Mun
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	WIDOWED DIVORCED   /VOU 16-145 / yrs 2 10   10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY)
P099-1-1-2-1-2-1-2-1-2-1-2-1-2-1-2-1-2-1-2	during most of working life, even if retired)  Thoughout  USA
Poges Poges at will	GEORGE ELLSWORTH COOK J. SHIRLEY ANDERSON
Giva File	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (If you, no, or unknown)
d in a	18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) ]
ol, on	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TREMMEDIATE  Angle:
Office of tra	Conditions, if any, which (b)
or o	gove rise to immediate couse (a), slating the underlying couse lost. (c)
Exam ad as	TO SHAPE IN OTHER SICANSTITIONS CONSTITIONS CONTRIBUTING TO DEATH BUT NOT DELAYED TO THE TEDUDINAL DISEASE CONDITION CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE OF THE TEDUDINAL DISEASE CONDITION CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CONDITIONS CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CHIEF IN BART NAMED CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CHIEF IN BART NAMED CHIEF IN BART NAMED AND TO SELVENTIAL DISEASE CHIEF IN BART NAM
dicol	PERFORMED?  YES NO  20a. EXTERNAL CAUSE WAS  PRIMARY Dor CONTRIBUTING D  CAUSE OF DEATH.  20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
word eef Me borid	
# 5 mg	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or fown) (County) (Store)  Hour o. m While Not while of work of work of work of work of work of work
	21. 1 certify that I taak charge of the remains described above, held an Autapsy . Inspection . Inquiry . ond in my
ficote, code, code,	opinion death resulted from: Natural causes . Accident . Suicide . Homicide . Undetermined manner .
DIRE pratec	ACTUAL SIGNATURE COLORS . M.D. CHIEF MEDICAL EXAMINER . DATE SIGNED  ASSISTANT MEDICAL EXAMINER .
de Se	( EXAMINER ) AMES / MARSH DEPUTY MEDICAL EXAMINER D
A ST	220 DATE THEREOF 220 NAME OF CEMETERY 220 LOCATION (City, town, or county) 15tors 1 28-1958 MT 210N
A15ME .	23 FUDIFICAL DIRECTOR'S S GNATURE WINTIELD. 240 REC'D BY REGISTRAR'S SIGNATURE
M 2/57	DATE JAN 2 8 'E8 COLLAND

BUREAU V. S.

WAI

PATER

d in by the funeral director, and 2 should be filed with

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the haspital or ottending physician.

TO FUT AL DIRECTOR: After this certificate has been signed by the attending physician and completely post anould be detached for use as the buriol-transit permit. Then please remove carbon papers. Post the registrar prior to buriol, cremation, or removal, and in event within 72 hours ofter death.

CERTIFICATE OF DEATH

Rea. Dist. No.

			1/4								Keg. DIST	, 140.		
1. [	a. COUNTY			MAR	/LAND	a. STATE					Residence	befar	e admissio	n)
ı	. CITY OR TOWN (H	OR TOWN (If outside carporate limits, write   c. LENGTH OF STAY IN 1b   c. CITY OR TOWN (If outside carporate limits							rate limits, wr	ite RUF	RAL and giv	ve near	est tawn)	V
R				17 days		P	altimo	re C1	tv				,	
_	NAME OF HOSPIT			address)				, , , , , , , , , , , , , , , , , , , ,				1	ts REST	DENCE
		ld State Ho	spit	al		1	613 W.	29th	. Stre	et.	18	ON A FARM?		
Ĺ	DECEASED	Joseph	s1	Norris	-		t	4. DATE OF DEATH		Month		Doy 27		iar 95음
<b>5</b> . S	EX	6. COLOR OR RACE	7. MARR	IED NEVER MARR	ED 🗀	8. DATE OF BIRT	Н		9. AGE (In ye	ears [	FUNDER 1	YEAR		400
]	Male	White	WIDOWE	ED DIVORCE	:D []	1-10-79	<u></u>			yrs :	Manths D	ауз	Havn	Min
100	. USUAL OCCUPATIO	N (Give kind af work o	iane 10b.	KIND OF BUSINESS	OR INDUS			ar fareian co	~ _	/	T12. CITIZ	EN OI	: WHAT	OUNTRYS
	aring west at wark	ing life, even if retired)												
13.	-	DIITDMI	. K. 41 U	OT ON Del			_							
		Cooper(	Geor	rge W.Coo	ner	1			n ? (	स्त	17.A	s.	Cla	nk
15.	WAS DECEASED EVE			30		NFORMANT	Altona D	4011101				-	020.	
	NO		N	V 1 1		spital I	Record	Mrs	Maud	A.	Coop	er	Sai	ne
				ne for (a), (b), and (c)	-]							INTE	VAL BET	WEEN
	PART I. DEA	IH WAS CAUSED BY: IMMEDIATE CAUSE (o	Cos	ronary Occ.	lusio	on								
	420.1	DUE TO												
	Canditians, if or	y, which ) (b)	Arte	eriosclero	tic o	cardiova	scular	dise	ase			ve	ars	
				*								-4/		
	lying cause last													
ATION	CITABILLE	er significant con Brain Synd	DITIONS C	CONTRIBUTING TO DE	ATH BUT	h cerebi	the terminal ar	terio:	condition	GIVEN 318	vin part i	(a) 19	PEREOR	MED?
IFIC			20b. DESC	CRIBE HOW INJURY O	CCURRE	) (Enter nature a	f injury in P	ort I ar Pari	II of item 18.	1			10 [2]	NO L
	(IF EITHER, NOTIFY	MEDICAL EXAMINER)								,				
AEDICA	Hovr a.m.	Month, Day, Yes	White	Nat while	20e PL/ foc	CE OF INJURY I	Home, form, bldg , etc.)	20f. (City	or town)		(Co	unly]		(State)
- 1		. 1 -44 3- 3 46			117713071	- 70 mm	. To		07.44	70				
	-15 or Jan	ai i attended the	decease	ed irom. <u>यद्य</u>	mary	المناتية المناسب	TOUSS	nary_	6_1, 19_	20,	that I la	st sa	w the d	eceased
	alive au fair	tory a	12	$29_{-}$ , and that	death	occurred at	DITUR	.M, tran	the cause	es an	d on the	dati		
	ACTUAL To	P 124	0					Ť			9	27		E SIGNED
	SIGNATURE JALL	ac K . /// u	zuu	ru,		M.D. Sprin	gilel	d Stai	te Hosi	oi te	1 7.	!	-50	
	PHYSICIAN'S IT	ene L. Hit	chman	n, M.D.		Sykes	ville	Mary	rland					
220	BURIAL, CREMATION	N, 226. DATE THEREO	F	22c. NAME OF CEM	ETERY O					VR, Of	county)		(State)	
	Burial	1/29/58	}	Mount 01	Live	t Ceme:	tery	Balt	timore	M	aryl	and		
23.	FUNERAL DIRECTOR'S	SIGNATURE		ADDRESS			24a, REC'D	BY REGIST						
	HENRY SA	NDER & SC	NS :	INC. BALT	CIMO	RE MD.	DATE	2 9 '58	Lu	71-1	raue :			
	3 15. 5. 5. 5. 1000 NOLY THE TOTAL T	b. CITY OR TOWN (III RURAL and give ne RURAL and	b. CITY OR TOWN (If outside carporate liming RURAL and give nearest town)  Sylvestille, Md  A NAME OF DECEASED  (Type or print)  SEX  A. COLOR OR RACE  White  100. USUAL OCCUPATION (Give kind af work of during most af working life, even if retired)  Carpenter Shipwri  13. FATHER'S NAME  JOHN HUBER COOPER (  15. WAS DECEASED EVER IN U. S. ARMED FOR (17th, not or unknown)  Iff yes, give wor or dofus of the NO  18. CAUSE OF DEATH (Enter only one companion)  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (of DUE TO Canditions, if ony, which gove rise to immediate course (o), storing the underlying course lost to immediate course (o), storing the underlying Chronic Brain Syncholic reaction  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY Month, Doy, Year Hour a. m.  P. m.  21. I certify that I attended the alive an Jamuary 27  ACTUAL SIGNATURE LUCLE A. HILL  PHYSICIAN'S Irene L. Hill  200. BURIAL CREMATION, 22b. DATE THEREO BURIAL CREMATION, 22c. DATE THEREO BURIAL C	b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Rural: Sykesville, Md.  d NAME OF HOSPITAL (If not in haspital, give street or NAME OF HOSPITAL (If not in haspital, give street or NAME OF HOSPITAL (If not in haspital, give street or NAME OF DECEASED (Type or print)  5. SEX   6. COLOR OR RACE   7. MARE MIDOWN 100. USUAL OCCUPATION (Give kind at wark dane) 100. diving most of warking life, even if retired)  102. USUAL OCCUPATION (Give kind at wark dane) 100. diving most of warking life, even if retired)  13. FATHER'S NAME  14. JOHN HUBER COOPER (GeO: Shipwright) 13. FATHER'S NAME  15. WAS DECEASEDEVER IN U. S. ARMED FORCES?  16. WILLIAM OF INJURY AND ARMED FORCES?  16. WILLIAM OF INJURY WHICH IN DIVING OF CONTRIBUTING OF CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  202. TIME OF INJURY MONTH, Day, Year 200. IF MOVE a. m.  203. ACCIDENT WAS UNDERLYING OF OPEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  204. The OF INJURY MONTH, Day, Year 200. IF MOVE a. m.  205. WAS UNDERLYING OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  206. TIME OF INJURY MONTH, Day, Year 200. IF MOVE a. m.  21. I certify that I attended the decease alive an Jamuary 27 19 CHAPTER SIGNATURE  207. BURIAL CREMATION, 22b. DATE THEREOF BURIAL CREMATION,	b. CITY OR TOWN (if outside carporate limits, write RURAL and give nearest town) RURAL and and give nearest town) RURAL and and town town town town town town town town	b. CITY OR TOWN (if outside carporate limits, write RURAL and give nearest town) RURAL and give nearest	a. COUNTY Carroll b. CITY OR TOWN (If obtide carporate limits, write RURAL and give nearest lown) RURAL and give street address lown and give nearest lown and give nearest lown. RURAL and give nearest lown and give nearest lown. RURAL and give nearest lown and give street address) RURAL and give street address lown and give street address) RURAL And give street address lown. RURAL And give street address lown and give street address lown. RURAL and give street address lown and give street address. RURAL STREET A. RURAL And give street address lown and give street address. RURAL STREET A.	a. COUNTY Carroll b. CITY OR TOWN (If obtide corporate limits, write RURAL and give nearest lown) Rural: Sykesville, Md.  d NAME OF HOSPITAL (If not in hapstol, give street address) OR INSTITUTION Cornin field State Hospital  3 NAME OF HOSPITAL (If not in hapstol, give street address) OR INSTITUTION Cornin field State Hospital  10 Ust 10 Copper  10 Ust 10 Copper 10 Ust 10 Copper 11 Ust 10 Copper 12 Ust 10 Copper 13 FATHER SNAME 14 JOHN Huber Cooper 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Its. SOCIAL SECURITY NO. INFORMANT NO  18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).  PART I. DEATH WAS CAUSED BY. Corning in winding the underlying couse lost  Corning in the underlying couse lost  Corning in the underlying couse lost  Corning Corning the Ust Synchrolic Corning C	a. COUNTY CATTOIL  b. CITY OR TOWN If obtide carporate limits, write RURAL ond give nearest lown) RURAL of NAME OF CONTROL (If not in hospitol. give street address)  3 NAME OF CONTROL (If not in hospitol. give street address)  3 NAME OF CONTROL (If not in hospitol. give street address)  4 NAME OF CONTROL (If not in hospitol. give street address)  5 SEX  4 COLOR OR RACE [7 MARRIED [ NEVER MARRIED [] 8. DATE OF BIRTH Male  5 SEX  5 COOPET  5 SEX  6 COLOR OR RACE [7 MARRIED [] NEVER MARRIED [] 8. DATE OF BIRTH Male  6 COLOR OR RACE [7 MARRIED [] NEVER MARRIED [] 1-10-75  100. USUAL OCCUPATION (Give bind at work done 106. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign or dolling most of working life, even it refired to Carporter Shipwright City Balto.  8 Balto. Maryland  13 FATHER'S NAME  13 JOHN Hubber Cooper (George W. Cooper)  15 MAS DECEASED EVER IN U. S. ARMED FORCES? [16. SOCIAL SECURITY NO. 17. INFORMANT  16 NONE  18 CAUSE OF DEATH (Enter only one course per line for (p), (b), and (g.]  19 PART J. DEATH WAS CAUSED BY.  19 JOHN Hubber Cooper (Cooper)  10 DUE TO  10 Conditions, if only, which gave rise to immediate course (p). Arteriosclerotic cardiovascular dise costs (e), Istoling the under life time, Not while gave rise to immediate course (c)  10 Conditions, if only, which gave rise to immediate course (c)  10 Conditions of the proper life to the proper life to the proper life time only one course per line for (p), (b), and (g.]  10 PATH J. DEATH WAS CAUSED BY.  11 JOHN HUBBER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED, TO THE TERMINAL DISEASE (c)  12 COLOR OF THE STORY HIS COURSE (c)  13 PATH J. DEATH STORY HIS COURSE (c)  14 DUE TO  15 PATH J. DEATH STORY HIS COURSE (c)  15 PATH J. DEATH STORY HIS COURSE (c)  16 COLOR OF THE STORY HIS COURSE (c)  17 PATH J. DEATH STORY HIS COURSE (c)  18 PATH J. DEATH	a. COUNTY Carroll b. CITY OF TOWN (If outside carporote limits, write RURAL on give nearest fown) Rural; Sylvesville, Md. 17 da.,'s  Rattimore City  A NAME OF CONSTITUTION Consistivition Control of the Aprile of State Hospital  North Cooper  First Joseph Norths Ander Of Bush Ander Of Bush Joseph Norths Cooper  First JOSEPH Norths Ander Of Bush JOSEPH Norths Mary Corran ? (  13. KARLE OF DEATH NORTHS NORTH	PLACE OF DEATH   CAPTOL   CA	1. MARC OF DEATH   2. USUAL BESIDENCE (Where deceased lived IV institution. Residence Carpoll   3. CATOOL   4. SATE   5. COUNTY   CARPOLL   5. COUNTY   CARPOLL   6. COUNTY	P. MACE OF PEATH   CATPOIT   MARYLAND   MARYL	P. PLACE OF DEATH   CATTOOL   CATT



BUREAU V. S.

hours ofter death.

within 24

that

O

BUREAU V. S.

DAV - VAL

VS A15 (4) 15M 10/57

M

0

ARYLAND STATE DEPARTMENT O	F HEALTH-BALTIMORE, 18
KRYLAND STATE DEPARTMENT O	F HEALTH-BALTIMORE, 18

M

00487

		. 49	4	CERT	IFIC/	ATE OF I	DEATH	ı	·	Rec. I	ist. No	( <b>/1</b> ()	4
î.	PLACE OF DEATH a. COUNTY	rroll		MAR	YLAND	o. STATE	DENCE (What	-	ed lived If institu	tion Resid	ence befo		on)
Γ	b CITY OR TOWN (	If autside corporate limit	, write	c. LENGTH OF STAY	IN 1b	c. CITY OR	TOWN (If or	ulside corp	orate limits, write			arest lowr	1)
_	Tanevto	•				X Ta	anevto	wn					
	OR INSTITUTION	FAL (If not in hospital, gi	ve street	oddress)		d STREET	ADDRESS Ltimor	e Str	rest				DENCE FARM?
3.	NAME OF DECEASED	Firs	1	Middle		Los		4. DATE		nih	Do	у	Yeor
	(Type or print)	Elmc	r	E.		Crubs		OF DEATH	Januar	v	(	6.	1958
5	SEX	6. COLOR OR RACE	7 MARR	IED NEVER MARR	ED 🗍	B. DATE OF BIRT	Н		9 AGE (In years	IF UNDE		IF UND	R 24 HRS
	ale	White	WIDOWS	DIVORCE	0	March 2	5. 197	6	lost birthdoy)	Months	Doys	Hours	Min.
100	during most of wor	ON (G ve kind of work d	one 10b.	KIND OF BUSINESS	OR INDU		LACE (Stote o	or foreign o	country)	12 C	ITIZEN C	F WHAT	COUNTRY
1.	Supt.		Ci	ty Water D	ent.	Na	arvlan	d			J.9	o die	
13	FATHER'S NAME					14. MOTHER'S	MAIDEN N	AME	***************************************				
	10.7	lliam E. Cr	ehs			या ।	zabeth	Darrh	off				
15	WAS DECEASED EVE	R IN U.S. ARMED FORC	ES? 16	SOCIAL SECURITY NO	). 17 1	NFORMANT	904 0 91			dress			
1	., .,	(ir yes, gree wer or ourse or se-	1	2-24-3017	9.1	rs. Hel	an 1111	terbr	rick. Tar	evtor	773 . T.	<sup>4</sup> ถหนไ	and
	18 CAUSE OF DEA	ATH (Enter only one cou	se per lir	e for (a), (b), and (c)	1			0 44 2	20 10 10 10 10			ERVAL BE	TWEEN
	PART I. DEA	TH WAS CAUSED BY:	Can		. 87	H. D.	unt	· to	4	/	ON	SET AND	DEATH
	1774	DUE TO		2220	W U	the P	Land Control	- LE	Chris			- 14	yu
	Conditions, if o	no which t			71	etas	tari						0
	gove rise to i	mmediote (D).	-				MAL	ν					
	lying couse lost.	The under-											
Ιž		HER SIGNIFICANT COND	ITIONS C	ONTRIBUTING TO DE	ATH BUT	NOT RELATED TO	THE TERMIN	JAI DISEAS	E CONDITION G	VENI INI PA	PT Vol 1	o WAS	ALITOPSY
ĮΥ			_					1716 187132713		VE14 1141 /	, , , , ,	PERFO	RMED?
IFIC	200 ACCIDENT WA	AS LINDERLYING [7]	20b. DESC	RIBE HOW INJURY O	CCURRE	) (Enter polyre o	f injury in P	net Lor Por	rt II of item 18.1			155	NO Z
CERTIFICATION	OR CONTRIBUTING	CAUSE OF DEATH MEDICAL EXAMINER)				or terror notara o	,,						
	20c. TIME OF INJUR		204 16	JURY OCCURRED	20- PL	ACE OF INJURY (	Home form	206 10%					41
MEDICA	Hour a m	19	While	Not while	foc	tory, street, office	e bldg., etc.)	201 (City	y or rownj		(County)		(Stole)
S	pm			of work	1 0 0	-	* 7						
	21. I certify th	at I attended the	decease				, to 16	rn 6	, 19 <u>.5</u>	S,that 1	last so	aw the	decease
	alive on	anco	_, 1 <u>2 3</u>	o, and that	death	occurred at	11:50A	M, frai	m the causes	and an	the da	te state	ed abave
		^	٠. ۵	A.A			,	4	itreet, city or town	, stote)		D#	TE SIGNE
	SIGNATURE_	rarlis /	W	illian	w	M.D	my	1, 15	bur	211	md	1-	8-58
	PHYSICIAN'S NAME (Type)	hARles	R.	Willia	ms								
22	BURIAL CREMATIO	N. 22b. DATE THEREOF		22c. NAME OF CEM	ETERY O	R CREMATORY		22d. LOCA	TION (City, town,	or county)		(Stote	e)
	REMOVAL (Specify)	1/2/58		Reformed	Ceme	sterv			rtorn, Ma	, ,		10.00	1
23.	FUNERAL DIRECTOR	S. SIGHATURE -	11-01	A GOTESS ]	4 4		24c REC'D					RØ	
0	.U.Fuss &	Son. " nev	245	1 -C-TU	12			AN 9	'58	2	due	1	
	3 × 3 × (41)	- C111 - 173 Y	- Y Y - 2 1 9	120,0		1.					-		

BOBEVA A' F

BECEINED

**ADDRESS** 

24g. REC'D BY REGISTRAR

24b REGISTRAR'S SIGNATURE

within 1SM 9/SS

EVA A'E

5561 15 No



BUTTAU V. S.

**CERTIFICATE OF DEATH** 

		VI							Keg. Dist	. 140.	
1. PLACE OF DEATH o. COUNTY Car	roll		MARY	LAND		ence (who		l lived. (f institution b. COUNTY	-	rroll	ission)
b. CITY OR TOWN (If a RURAL and give near		ls, write	c. LENGTH OF STAY	IN JP	c. CITY OR TO	OWN (If or	itside corpoi	rate limits, write R	URAL ond gr	ve nearest to	wn)
Mt. Airy-R		<i>#</i> 3	Years	.	M:	t. Al	ry–Rui	al-R.D.#	3		
d. NAME OF HOSPITAL	(If not in hospital, g	ive street c	oddress)		d. STREET AD	DRESS				e. IS R	ESIDENCE A FARM?
Near Ridge	ville				No.	ear R	idgev:	llle			NO 🗆
3. NAME OF DECEASED (Type or print)	Fin HELI		Middle CHRIS	TINA	DEC!	KER	4. DATE OF DEATH	Janu		Doy 20,	Yeor 1が8
	. COLOR OR RACE	7. MARR	ED A NEVER MARRI	ED 🔲 8.	DATE OF BIRTH			9. AGE (In years lost birthday)	7	YEAR IF UN	IDER 24 HRS.
Female	White	WIDOWE		- J.V	March 26.	190	6	51 yrs.	MONTHS L	Days Hour	rs Min.
10a. USUAL OCCUPATION during most of working	(Give kind of work of life, even if retired)	lane 10b.	KIND OF BUSINESS O	R INDUST	RY 11. BIRTHPLA	CE (State o	or foreign co	iuntry)	12 CITIZ	EN OF WH	AT COUNTRY?
Housewif			Domestic			Mar	yland			USA	
13. FATHER'S NAME					14. MOTHER'S /	WAIDEN N	AME				
<u>Eu</u>	getje A. Ro	oelke				Susar	n Rick	cerd			
15. WAS DECEASED EVER I	N U. S. ARMED FOR			17. IN	FORMANT			Add	ess		
No	No	Ur	ıknown	Mr.	Melvin	H. D	ecker.	Sr.Mt.	Airy F	1.D.#3	Md.
PART I. DEATH	[Enter only one co   WAS CAUSED BY:  MEDIATE CAUSE (o)	10	g for (0), (b), and (c).	1	na 07	de	VER	win	K	INTERVAL ONSET AN	BETWEEN ID DEATH
/ , , ,	DUE TO	201	meral	90	rethon	P	1				
Conditions, if any			mount	Ur	Conve	a					
gove rise to imm cotte (a), stating the											
lying cause lost.	} (c)									L	
PART II. OTHER	SIGNIFICANT CON	DITIONS	ONTRIBUTING TO DE	ATH BUT N	NOT RELATED TO 1	THE TERMIN	NAL DISEASE	CONDITION GIV	EN IN PART	PERF	S AUTOPSY FORMED?
	UNDERLYING TO CAUSE OF DEATH EDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY O	CCURRED.	. (Enter nature of	injury in P	ort Lar Port	II of item 18.)			
ZOc. TIME OF INJURY Hour a. m. p. m.	Month, Day, Yes	While	Not while	20e. PLAC Focto	CE OF INJURY IN- try, street, office	ome, form, bldg., etc.)	20f. (City	or lawn)	(Co	ounty)	(State)
21. I certify that	Lattended the	decease	ed from all	E.	. 19.57	to (	an	20, 195	Zthat I Is	et caw th	e deceased
olive on M	20	105	71	X	occurred at	1012	LM from	the causes o			
10		1		acejii (	C			rest, city or town,			DATE SIGNED
ACTUAL SIGNATURE	my	and	tool	C	n //	7/X	- (li	ire X	Ud	/	1-20-
PHYSICIAN'S NAME (Type)	MVa	N to	do/e		1.00	et andrastille are effected as		8			
220. BURIAL, CREMATION,	226. DATE THEREO	F	22c. NAME OF CEM	ETERY OR	CREMATORY		22d. LOCAT	ION (City, town, o	r county)	(St	ote)
REMOVAL (Specify)	Jan. 23.1	958	Mount Ol	ivet.	Cemetarr		Frede			,	yland
23. FUNERAL DIRECTOR'S		7,0	ADDRESS	- V ( ) X			BY REGIST		STRAR'S SIGN		
M. R. Etch:	ison & Sor	Fre	ederick, Ma	aryla	and	DATE 4	<b>2</b> 2	*58 { <sub>U</sub> }	· Polis	ichi.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician.

TO FULL AL DIRECTOR: After this certificate has been signed by the attending physician and campletely ATA of in by the funeral director, page hauld be detached for use as the burial-transit permit. Then please remove carbon papers. Power and 2 shauld be filled with the registrar prior to burial, crematian, or remaval, and in any event within 72 haurs after death.

EULLI V. S.

DECENAEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. K.

BECEINED

MARYLAND	STATE DEPARTMENT	OF	HEALTH-BALTIMORE,	18
479	CERTIFICATE	OF	DEATH	_

9 CEKTIFICATE OF DEAT	9	CERTIFICATE	OF DEATH
-----------------------	---	-------------	----------

00492

916				Reg. Dist. No.	
1. PLACE OF DEATH o. COUNTY		2 USUAL RESIDENCE (Where	deceased lived. If institution	Residence before ad	lmission)
CARROLL	MARYLAND	M.D.	b. COUNTY	UPRO 4	- 4-
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 15	c. CITY OR TOWN (If outs	side carporate limits, write RUR	AL and give nearest	townj
WESTMINSTER	92 4133.	WESTM	INSTES	2 . 7	
d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION	address)	d. STREET ADDRESS			RESIDENCE N A FARM?
48 LIBERTY )T		18 LIBER	TTST		S NO C
3 NAME OF First	Middle	Last 4	DATE Month	Day .	Year
(Type or print) ( A SSIE	DRIS	SCOLL	DEATH JAN	3	1958
S SEX 6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED	B. DATE OF BIRTH		FUNDER I YEAR IF U	-
+ W widow	/ED DIVORCED	7-28-186:	5 92 m.	Manths Doys Ho	ors Min,
10a. USUAL OCCUPATION (Give kind of wark done 10b. during most of working life, even if retired)	. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stole or	foreign country)	12. CITIZEN OF WI	HAT COUNTRY?
NOHIE		MA		US	. A .
13. FATHER'S NAME		14. MOTHER'S MAIDEN NA	WE		
JOHN PRISCO	277	MAIRY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16.  IYas, no. or unknown)   (If yes, give wor or dates of service)	SOCIAL SECURITY NO. 17.	NFORMANT	Addjes	484131	ERIYS
100	ONE 111	RSCTABRY 110	SOMIZ WE	STMIYY	STERM
1B. CAUSE OF DEATH [Enter only one cause per	ine for (0) (b), and (c).]	0 0	10		L BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	includase	eller Kena	Carease	15	400
440X DUE TO . C.	0.0 6	2			1 4
Canditians, if any, which (b)	energy !	Irundeal	o linemia	120	900
gove rise to immediate Codse (a), stating the under-	, .				
lying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINA	IL DISEASE CONDITION GIVEN	1 IN PART 1(0) 19. W	AS AUTOPSY REORMED?
					□ NO □
OR CONTRIBUTING   CAUSE OF DEATH	CRIBE HOW INJURY OCCURRE	D. (Enler noture of injury in Par	t I or Part II of item 18.)		
i i i i i i i i i i i i i i i i i i i	I 5-	ACE OF INJURY (Home, farm, ctary, street, office bldg., etc.)	20f. (City or town)	(County)	(Stote)
Hour o. m. p. m. 19 of we	Not while or work of	Clory, sireel, billice diog., etc.)			
21. I certify that I attended the decea	sed from Yeur	C. 1940 10 46	ur 3 1058	that I last saw t	ha deceased
alive on Lens 3 199	SK , and that death	occurred at ///out	M, from the causes an		
11,10.11	11.11. 0	- ( ) / -49	ORESS (Street, city of town, sto	pie)	DATE SIGNED
SIGNATURE LECUSE	Meches	Mp. Wests	unster	md.	1/6/58
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-	11
PHYSICIAN'S NAME (Type)					
220 BURIAL CREMATION, 225. DATE THEREOF	22c. NAME OF CEMETERY	R CREMATORY 2	2d. LOCATION (City, town, or	county) (	State)
FIGURIAL 1-7-1958	ST. longs	ENETERT	WESTMIN	STER.	Mp.
23 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	0 / 24c. REC'D 8	BY REGISTRAR 245 REGISTS	RAR'S SIGNATURE	
David 4 Banhard	Westringley	Ma. DATE JA	N2 1 '58 1219	Leauch	

TEGEIVER 21.1913

BUREAU V. S

00493

£	L		433	CERTIFICA	TIE OI DEATI	•	Reg. Dist. No	0.
**	1.	PLACE OF DEATH			2. USUAL RESIDENCE (WI	nere deceased lived. If instituti		ore admission)
P	Н	Carroll		MARYLAND	o. STATE Mary	and b. COUNTY	Balto.	City
<u> </u>		b. CITY OR TOWN (If outside corporate	e limits, write	c. LENGTH OF STAY IN 15		outside carporote limits, write R		
	П	RURAL and give nearest town) Sykesville	1	19yrs.11mos.1	dava Balt	imore. 24	21/11	
15		d. NAME OF HOSPITAL (If not in hospi OR INSTITUTION	tol, give street od	(dress)	d. STREET ADDRESS			e. IS RESIDENCE
15	L	Springfield State			3314 O'Lonne	ell Street		YES NOTE
	3.	NAME OF DECEASED	First	Middle	last	4. DATE Mon	th C	lay Year
	П	(Type or print)	eorge	J.	EBERT	of Janua	ry 2	1958
	5.	SEX 6. COLOR OR R	ACE 7 MARRIE	D NEVER MARRIED	B. DATE OF BIRTH	9. AGE (in years		R IF UNDER 24 HRS
		Male White	WIDOWED		October, 18		Months Days	Hours Min.
1	10	. USUAL OCCUPATION (Give kind of a during most of working life, even if re	vark done 10b. Ki	IND OF BUSINESS OR INDUS	TRY 11. BIRTHPLACE (State	or foreign country)	12. CITIZEN	OF WHAT COUNTRY
		Advertising Busin	ess	-	Maryla	nd	U.	S.A.
	13.	FATHER'S NAME			14. MOTHER'S MAIDEN P	AME		
and the same of th		John Ebert			Mary Ste	einberger		
		WAS DECEASED EVER IN U. S ARMED		DCIAL SECURITY NO. 17. H	FORMANT	Add	/611	
	Ĺ	No -		- S	pringfield H	ospital Record	S	
		1B. CAUSE OF DEATH [Enter only o	ne couse per line	for (a) (b), and (c).]			IN	TERVAL BETWEEN
		PART I. DEATH WAS CAUSED IMMEDIATE CAU	SE (o) Epic	dermoid carcin	oma of tonsi	1		Months
	Н	145.0 DL	E TO					
		Conditions, if ony, which	(b)	*				
	H	gove rise to immediate DL couse (a), stating the under-	E TO	-				
	_	lying cause lost.	(c)					
	CATION	C.B.S. associated	CONDITIONS CO	NTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM	NAI DISEASE CONDITION GIVE	EN IN PART 1(o)	19. WAS AUTOPSY PERFORMED?
	3	psychotic i	reaction.	•				YES NO
	CERTIF	200. ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING   CAUSE OF DE (IF EITHER, NOTIFY MEDICAL EXAMIN	] 206. DESCR ATH (ER)	IBE HOW INJURY OCCURRED	Enter nature of injury in t	Port I or Part II of item 18.)		
	CAL	20c. TIME OF INJURY Month, Doy,			CE OF INJURY IHome, form		(County	(Stote)
	MEDICAL	Hour o.m. p. m.	19 While of work	IAOI MUITE	tory, street, office bldg., etc	.) *		
		21. I certify that I attended	the deceases	from March 7.	10.55 in Jai	nuary 23., 1958	that I last s	au the decease
		olive on January 22,	19.58		occurred at 4:30	A.M. fram the causes o		ate stated above
						ADDRESS (Street, city or town	statel	DATE SIGNE
	П	ACTUAL SIGNATURE TUSM	n cle	ll Camp	of Springfie	ld State Hospi	tal	1/23/58
- /	П	. //	•	/			**********	
	_	PHYSICIAN'S Agustin o	lelCampo,	, M.D.	Sykesvill	e, Maryland		
	220	BUR AL, CREMATION, 226. DATE TH	EREOF	22c NAME OF CEMETERY OF	CREMATORY	22d LOCATION (City, town,	or county)	(State)
		BURIAL 1-21	0-58	SACRED HE	FART CEM.	7401 GERMAN	HILLR	D. MD
	23.	FUNERAL PIRECTOR'S SIGNATURE	0 9	ADDRESS OUR DE	26 ST. 240. REC'	D BY REGISTRAR 245, REGIS	STRAR'S SIGNATU	JRE
		Maries	VI	0120	ALTO 24 MA DUAN 2	2 4 '58		

BULLAN K. K.

WI ALENSIN

PUREAU V. L.

EDST 71 NAI

BECEINED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



00496

CERTIFICATE OF DEATH Reg. Dist. No. 1. PLACE OF DEATH o. COUNTY Carroll 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) **b** COUNTY MARYLAND Marvland Frederick b. CITY OR TOWN (If outside corporate limits, write c LENGTH OF STAY IN 16 e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Mt. Airy - Route #h Rural - Sykesyille since 5-7-57 d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS a. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO NAME OF Middle 4. DATE Lost Manth Year OF DEATH (Type or print) 1958 Edward DVRT,Y January S. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years lost birthdoy) 87 yrs October 12. Months male 1870 WIDOWED 373 DIVORCED [7] 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Farming Mt. Airy, Maryland United States 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Evely Lizzie Poole Address Sykesville, Md. IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO no unknown Records of Springfield State Hospital 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) Bronchooneumonia dav Generalized arterics clerosis (severe) Conditions, if ony, which many years gave rise to immediate DUE TO couse (e), stoting the underlying couse lost PART IT OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) 19. WAS AUTOPSY Chronic brain syndrome associated with circulatory disturbance, with PERFORMED? cerebral arterios clerosis, with psychotic reaction.
20a. ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW IN. JRY OCCURRED (Enter noture of in ury in Port | or Port || of item || | YES TO NO IX 20g. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY 20d INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc. Hoor D. M Not while of work of work 19 57, 10 Jan. 14 21. I certify that I attended the deceased from July 16 ... 19\_58, that I last saw the deceased 4958 / and that death accurred at 2:25 PM, from the causes and on the date stated above. glive on January Ile ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Springfield State Hospital PHYSICIAN'S Sykesville. Maryland Walter Knopp. M. D. NAME (Type) 220 BURIAL, CREMATION, 226. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or county) (State) Burial Md. I7.58 Etchison Jan. Meth. Etchi 245 REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR



00497

1. PLACE OF DEATH 0. COUNTY AD	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE b. COUNTY
Carroll MARYLAND	maruland Carroll
b. CITY OR TOWN (If outside corporate fimits, write RURAL and give nearest fawn)	
d NAME OF HOSPITAL (If not in browning give street address)	d STREET ADDRESS 6 15 RESIDENCE
d NAME OF HOSPIAL (If not in hospital, give street address) OR INSTITUTION	ON A FARM?
	YES NO 12
3. NAME OF First Middle  (Type or print) SAMUE!  J Middle	706 LE OF DEATH Jan Jan 1958
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24 HRS
M WIDOWED DIVORCED	april 11, 1864 g3 yrs. Months Doys Hours Min.
100 USUAL OCCUPATION (Give kind of wark done 10b. KIND OF BUSINESS OR INC. during most of warking life, even if relired)	
Carpenter own business	s maryland USA
13. FATHER'S HAME	14. MOTHER'S MAIDEN NAME
John W. Fogle	Cerria Hyder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (19 yes, give wer or dotes of service)	INFORMANT Address
140   578-26-31991	ur Charles J. Forgle, Diskessable, R.F.D3, Md
18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Can dear Carrier	t, Cerebal bimontice,
DUE TO	Jul 57
Conditions, if any, which } the Night herm fli	- m, arteres ulpain Generalist I The
gave rise to immediate	
lying couse last.	heart dearence It Jun 58
	UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BY  200. ACCIDENT WAS UNDERLYING TO DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	PERFORMED? YES NO N
200. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCUR	RED. (Enter nature of injury in Part I or Part II of item 18.)
	PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg., etc.)
While Not while of work of work	
21. I certify that I attended the deceased from. July	
alive on 14 gam, 1958, and that dea	th occurred at (1:20 A M) from the causes and on the date stated above
1/21 101	ADDRESS (Street, city or town, state) DATE SIGNE
SIGNATURE XTOWARD & Nell	Mp. A Sheerelle, ned 14 Jan S
NAME (Type) HOWARD E. HALL	
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY	CRESHMATORY 22d. LOCATION-(City, town, or county) (State)
Burial Jan 16 58 Beans D	am profokusville Fred Co. Med.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE
120 1 Darlon 11 alken	WYPE WAS DATE JAN 1 Y'58 Chin edian A

BUREAU Y. S.

WE CELLY ELL

wilhin 24

and campletely

þ

RECTOR:

0

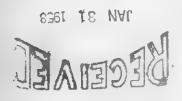


BUREAU V. E.

8SEI € N√1

MARYLA	ND STATE DE	PARTME	NT OF HEAL	TH-BAL	TIMORE, 1	8					
,	505 CE	RTIFICA	TE OF DEA	TH	Reg. Dist.	() () () 499 Reg. Dist. No.					
11		MARYLAND	2. USUAL RESIDENCE ( O STATEMARY 1	Where deceased		altim		ion)			
its de corporate l'm is, wi st lown) Le		STAY IN 16	c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town)  Cockeysville (rural),								
en Nursing			d street address  Falls Rd.  • 15 residence On a farm? YES 1 NO □								
Irene		Aiddle orence	Fowble	4. DATE OF DEATH	Jan			Year 1958			
107-2 4-	MARRIED NEVER M		DATE OF BIRTH 8-31-1870		9 AGE (In years less b rindoy) 87 yrs		YEAR IF UNDE	Min			
Give kind of work done life, even if retired)	10b. KIND OF BUSINE	ESS OR INDÚSTI	RY 11. BIRTHPLACE (SIGNATURE) Maryla	_	ountry)	1	S.A.	COUNTRY?			
Cole			Nancy	N NAME Wheele	er						
I U. S ARMED FORCES? n, give war er dales of service]			formant s. Grace	Akehur	st, Mon		Md.				
[Enter only one cause p	per line for (a), (b) on	d (c) ]					INTERVAL BE				

D. PLACE OF DEATH Carro b CITY OR TOWN ( F ou Sykesvil d NAME OF HOSPITAL Pulle NAME OF DECEASED (Type at print) 5 SEX Female 10a. USUAL OCCUPATION housewife 13. FATHER'S NAME J. Best 15 WAS DECEASED EVER IN no. 18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiec Decompensation 2 W.C3. 4201 DUE TO Arteriosclerotic C-V. Disease Conditions, if ony, which gave rise to immediate DUE TO cause (a), stating the underlying couse lost. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19. WAS AUTOPSY PERFORMED? YES NO none 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH none MEDICAL 20c TIME OF INJURY 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, 20f (City or lawn) (County) (State) factory, street, office bldg., etc.) Not while none at work at work ⊓nbne none 1958, that I last saw the deceased 21. I certify that I attended the deceased from Jon. 19, and that death occurred at  $8:30 \,\mathrm{AM}$ , from the causes and an the date stated above DATE SIGNED 6 Honover Rd SIGNATURE PHYSICIAN'S Reisterstown 220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) 27c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, fown, or county) (Slate) Black Rock Butler, Maryland 24a. REC'D BY REGISTRAR 275. REGISTRAR'S SIGNATURE 622 York Rd., Towson4, Md DATE JAN 3 1



BURRAU V, K.

1			MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	
FOR STA	TE		506 CAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.	
ALTH D	EPT.		LACE OF DEATH    2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
- 15, -	-		COUNTY CARROLL MARYLAND G. STATE MARYLANDS COUNTY FREDERICK	1
1 /E E.	4	b	CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest fown)	_
\$ 5 TO TO	1		TANEYTOWN HOURS RURAL EMMITS BURGI	
For	£ 1)	9	NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d STREET ADDRESS  e is residence ON A FARM?	
ined ined in the British			HANOVEK ST. VES NO	Z
5 6 4 9		3.	NAME OF First Middle COST 4. DATE Month Day Year McCEASED OF MES FRANK GARBER DEATH JAN 14 195	8
e Le		5. S	EX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED A B DATE OF BIRTH 9 AGE HIS years I FUNDER LYEAR IF UNDER 24 HR	5
T T T T T T T T T T T T T T T T T T T			M WIDOWED DIVORCED DAUGE 16 - 1899 Lord birthdey) Annths Days Hours Min.	
296 5 20 2 72 hr		10a	USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. B RTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY Using most of working life, even if retired)	i¥7
10 - E	<b>d</b>	_	DAY WORKER KUBBER FACTORY MARYLAND USIT	77.00
M3.		13.	FATHER'S NAME  14. MOTHER'S MAIDEN NAME  10. D.D. T. D. D.D. T. D.	
d d d		15.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Address	
SE E		[Yes	NO 1 1 you give mar or days of retrices 214-28-0047 MRS CARROLL WICKLESS WOODS BORD M.	7)
E E			18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c) ]  [Interval State of Death of	_
and in			PART I. DEATH WAS CAUSED BY: ON A TY OEL LUSION METAL ONSET AND DEATH THE	
onsi You			420./ DUE 10	
8 <u>10 </u> §			Conditions, if any, which (b) gave rise to immediate cause	
ة مُونِّة			(o), stating the underlying DUE TO	
ion,		Z	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19. WAS AUTOPSY	_
THE SECTION OF THE SE	0	ATIO	PERFORMED?	/
Page 5		THE	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTION CAUSE OF DEATH.  20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18)	
M Dio		CERTIF	CAUSE OF DEATH.	
e da o		MEDICAL	20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e FLACE OF INJURY (Home, form, 20f. (City or town) (County) (State)	
0 0 0		ME	p. m 19 of work of work	
5 9			21. I certify that I took charge of the remains described above, held on Autopsy . Inspection . Inquiry . and in my	У
TOR OF			opinion deot resulted from: Notural causes . Accident . Suicide . Homicide . Undetermined manner .	
Ed o			ACTUAL DATE SIGNED DATE SIGNED	,
gaot to g	ξ		ASSISTANT MEDICAL EXAMINER ()	-
de Si			NAME (Type) AMES IN ARS DEPUTY MEDICAL EXAMINER TO	C
		220	BORNAT CREMATION 226. DATE THEREOF 22C NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county) (Slote)	70-
5 2 b		I	BURIAL 1117/58 MT HOPE WOODSBORD MD	
A15ME	)	23. P	A Design of the Asset of the As	
2/57	C. A.	16	WELL-YHHKIZLEK WOODS BORG MUD DATE SANT 1'58 ( CO. CALLER	-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



8361 41 1



death.

O HOSPITAL

SECTION NO SECTION NO

Y\$ A15 (4) 15M 9/55 18

15

		MAKT	50	Q CEDTIE		ATE OF DEA		LIIMOKE,	18	00	95	02
L			O V	CERTIF	101	AIE OF DEA	чи		Reg. Dis	I. No.		0 2
1.	PLACE OF DEATH o. COUNTY					2. USUAL RESIDENC	E (Where deceo			e before a	dmissio	n)
L	Car	roll		MARYL	AND		rland	b. COUNTY	Cá tr	v		
	b. CITY OR TOWN (I RURAL and give no	If outside corporate limi	ts, write	c. LENGTH OF STAY IN	4 1P	c. CITY OR TOWN	d (If outside corp	porote limits, write l			town)	
	Sykesy					Baltime	ore 18.N	18.		1		
Γ	d. NAME OF HOSPIT	AL (If not in hospital, g	ive street	oddress)		d. STREET ADDRE				e. IS	RESIC	DENCE
		field State	-			2056 Ker	mader An	ronuo.			ON A F	
3.	NAME OF	Fire		Middle		Lost	4. DATE		nth.	Day	Ye	ar
	OFCEASED (Type or print)	How	rell	Reese		Gatchell	OF DEAT			78		
5.	SEX			RIED NEVER MARRIED		B. DATE OF BIRTH		9. AGE (In years	IF UNDER	LO TYEAR IF U		9 58
	Male	470 44	WIDOW		_	9-20-81		lost birthdoy)			SULS	Min.
10		White		KIND OF BUSINESS OR	-	A - 4 - 4-	State or foreign		12 (17)	ZEN OF W	HATC	CHAR
	Bookkeep	king life, even it retired	100.	KIND OF BUSINESS OR	11100	37		Cooming			HAI L	,OUNTR
12	FATHER'S NAME	CI		<del> </del>	_	14. MOTHER'S MAIO			1 0	.S.A.		
"		owell Gatch	-77					D				
-					1	Hettie	Maria					
13.	it, no, or unknown)	K IN U. 5, AKMED FOK Jif yes, give war or dates of s	ervice)	SOCIAL SECURITY NO.		NFORMANT		Add	rass			
L	no			unkn	S	pr.St.Hospi	ital Rec	cords				
				ne for (o), (b), and (c).]						INTERVA ONSET	L BETY	WEEN
	PARI I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	Ar	teriolar ne	phr	osclerosis				day	5	LEGITI
	e twee	DUE TO										
	Conditions, if or		Arte	rioscleroti	c c	ardiovascul	Lar diee	2250		ye:	ars	
	gove rise to it											
	lying couse lost.	) (c										
ő	PART II. OTI-	ER SIGNIFICANT CON	DITIONS	CONTRIBUTING TO DEAT	H BUT	NOT RELATED TO THE	TERMINAL DISEA	SE CONDITION GIV	ZEN IN PART	1(o) 19. W	AS AL	JTOPSY
CERTIFICATION	Uhr. bra:	in syndr. a	ssoc	.with senil	e b	rain diseas	se with	psych.res	ection	PE	:RFOR/	MED?
THE STATE OF	20a. ACCIDENT WA	S UNDERLYING	20b. DES	CRIBE HOW INJURY OC	CURRE	2. (Enter nature of inju	ry in Port I or Po	ort II of item 18 )				
8	(IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)										
MEDICAL	20c. TIME OF INJUR	Y Month, Day, Yes	r 20d. I	NJURY OCCURRED 2	Oe. PL/	CE OF INJURY IHome,	farm, 20f. (Ci	ity or town)	IC	ounty)		(Stote)
4ED1	Hour o. j., p. m.	19	While of wor		foc	tory, street, office bldg	., elc.)		1-			40.010
~					0.0	7 77.	2 20	7.5				
	l m	at I attended the		ed from	4=4	7 <u>-5719</u> , to	<del></del>	19.50	_,that i la	ast saw t	he d	eceas
	alive onL		_ 125	$\Omega/J$ , and that d	leath	accurred at 1:3				e date s		
	ACTUAL %	ture d	, 4	tu store	200	-		Street, city or town.				E SIGN
	SIGNATURE CE	7000				M.D. Springs	ield St	ate Hospi	tal		<u></u>	18-5
	PHYSICIAN'S	_										
	NAME (Type)	Edmind I						ryland.				
224	<ul> <li>BURIAL, CREMATIO REMOVAL (Specify)</li> </ul>	N, 226. DATE THEREO	F	22c. NAME OF CEMET		RCREMATORY	22d. LOC	ATION (City, town,	or county)		Stote	
_	urial	Jan. 20.	1958	Green Mo	uIIU		Balti	rore,		Md	•	
	FUNERAL DIRECTOR		-	ADDRESS		24a.	REC'D BY REGIS	STRAR 24b. REGI	TRAR'S SIG	NATURE		
J)	onn U. Mit	chell & Sor	is In	c. 1900 Eut	aw	FI. Baltom		E0 (000)	l oder	ch		

BULLING N. E.

1

		Ę.	50	9 CERTIFIC	ATE OF	DEATH	l .		Reg. Dist.		0503
1.	PLACE OF DEATH	Carroll		MARYLAND	2. USUAL RESI	bence (wh laryla	ere decessed live	d If institute b. COUNTY	on: Residence	befare adn	nission)
	b. CITY OR TOWN (If RURAL ond give no		ts, write	c LENGTH OF STAY IN 16	10		ore Cit	4	URAL and give	nearest to	own)
·	d. NAME OF HOSPITA OR INSTITUTION			oddress) te Yospital	d STREET		· "ii ;hla	and Ave	2 4		RESIDENCE I A FARM? INO P
3.	NAME OF DECEASED (Type or print)	fi Ire		Middle Lillian	Habicl		4. DATE OF DEATH	Mon	th	Day	Year 19 5 8
5.	F F	6. COLOR OR RACE	7. MARK	ED NEVER MARRIED DED DIVORCED	0. DATE OF BIRT			GE (In years as t inday)	Months Do	EAR IF UN	
10	during most of works	ng life, even if retired	dane 10b.	KIND OF BUSINESS OR INDI Store		rylan		у)	12. CITIZE	USA	AT COUNTRY?
13	FATHER'S NAME				14 MOTHER'S						
L	William .					nie H	ines				
	WAS DECEASED EVER	IN U. S ARMED FOR Eyes, give wor or dates of s	ervice]	19-32-1976	INFORMANT ST	ringf	ield Mos	Adde pital		S	
		7		ne far (a), (b), and (c) ]	1	_	6	A S	J	INTERVAL	BETWEEN ND DEATH
	PART I. DEAI	H WAS CAUSED BY IMMEDIATE CAUSE (o	Le	rebyal ca	voliov	arch	CRV 1	tcore	rent	4	dey
	32 84 X	DUE TO		erebral	thro	10	A C . c			u	weeth
	Conditions, if on gave rise to in	mediate									
7	couse (o), stoting the under: Due TO generalized Atlenosclerosis years  [c] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 1P. WAS AUTOPSY										
CERTIFICATION	Chronic b	rain synd: reaction	rome	associated wit	th cerebr	al ar	teriosci	erosis	WITH	PER	S AUTOPSY FORMED?
		S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURR	ED (Enter nature o	of injury in f	art I ar Part () o	fitem 18 )			
MEDICAL	20c. TIME OF INJURY Have a.m.	Month, Doy, Ye	While	NJURY OCCURRED 20e. P Not while t at work	LACE OF INJURY ( octory, street, affic	Home, farm e bidg , etc.	20f. (City or I	own)	(Coe	nty)	(Stale)
	21. I certify the	at I attended the	deceas	ed from Februar	y 15 <sub>919</sub> 57	_, ta	- 4	19 58	"that I las	t saw th	e deceased
	alive an	- 3	, 12		h accurred at	6 10 A	_M, fram th	e causes a	nd on the	date sta	ated abave.
	ACTUAL SIGNATURE GET	Tued Soull	upi	M. J. Spring,	Hidd Har		ADDRESS (Street,				DATE SIGNED
	PHYSICIAN'S BE	RTRUD	CNN	ENFELDT, M	(.P.						
22	BREMOVAL TOPOCIFY)	1-7-5		Oak La m			22d. LOCATION	altim	or county)		and
23	FUNERAL DIRECTOR'S			ADDRESS			BY REGISTRAR	24b. REG19	TRAR'S SIGN	ATURE	
40	onn C. Ni.	ller Inc.	-24	31 E. Oliver	St.	DATE	8 '54	( VO2 n		*	
-								13	Little		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



00504

510 CERTIFICATE OF DEATH

Reg. Dist. No.

_														
1,	1. PLACE OF DEATH  o. COUNTY  Carroll MARYLAND						2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Balto.City							
	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			20yrs.10mo	c. CITY OR TOWN (If outside corporate limits, write RURAL and give rearest town)  days:  Baltimore							<i>V</i> .		
	d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital					d STREET ADDRESS 2745 N. Calvert St.					e. IS RESIDENCE ON A FARM? YES NO 2			
3	NAME OF DECEASED (Type or pont)	Fint George		Middle Ernest		Los		4. DATE OF DEATH	January		13, Yeor			
	sex Male	White	WIDOW	hand		March :	29, 18		9. AGE (In years last builday) yrs.	Months .		OUTS	24 HRS Min	
10 Fi	during most of work ace Track	Racing			TRY 11. BIRTHPLACE (Stote or foreign of Maryland		country) 12. CII		TIZEN OF WHAT COUNTRY					
13.	Charles C. Hall					14. MOTHER'S MAIDEN NAME Margaret Todd								
15. (Ye	WAS DECEASED EVEN	DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Springfield Hospital Records												
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (a)  Uremi.a										INTERVAL BETWEEN ONSET AND DEATH Days			
	Conditions, if any, which gove rise to Immediate couse (o), stoting the under lying couse last.							nephrosclerosis				Years		
CERTIFICATION	PART II. OTH Manic De	epressive R	eact:	ion, manic	type	•				EN IN PART	P	VAS AUT ERFORM S N	ED?	
MEDICAL													(State)	
?	21. I certify that I attended the deceased from July 1. 1950, to January 13. 1958, that I last sow the deceased alive on January 121 1958, and that death occurred at 7:15A M, from the causes and an the date stated above ADDRESS (Street, city or town, stote)  ACTUAL SIGNATURE W. Springfield State Hospital 1/13/58													
	PHYSICIAN'S Walther H. Somnenfeldt, M.D. Sykesville, Maryland.													
L	REMOVAL (Specify)	1/15/58		22c. NAME OF CEME Mount Ol					ion (City, town, o			(Stote)		
23.	FUNERAL DIRECTOR'S	SECULO COM	Bon	ADDRESS 805 N. (	Calv	ert St.	240. REC'D	BY REGIST	RAR 24b. REGIS		11			

SA AVII.

within

certificate

O HOSPITAL

BUREAU K. S.

24a. REC'P BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

23. FUNERAL DIRECTOR'S SIGNATURE

Z .V UASCIII

MAN TO THE

VS A15 (4) 15M 9/5S

ARYLAND	STATE DE	PARTMENT	OF HEA	LTH-BALTIA	MORE,	18
240						

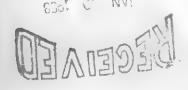
513 CERTIFICATE OF DEATH

M

Reg. Dist. No.

00507

1. PLACE OF DEATH	ro <b>ll</b>		MARYL	AND	o STATE	DENCE (WA	and the same	d lived. If instit b. COUN		sidence bel	fare admiss	ion)
B CITY OR TOWN (III RURAL and give ne Rural - Sy			since 4-26-			town (# o	3	orale limits, write	e RURAL	and give n	earest tawn	) /
A NAME OF HOSPIT	At (If not in hospitol, gield State	ive street	oddress)		d STREET A		ling	Street				IDENCE FARM? NO [2]
3 NAME OF DECEASED (Type or print)	Frank		Christia	n	HULSEM		4. DATE OF DEATH	_	Aonth Anua		-,	Yeor 1958
5. sex male	6. COLOR OR RACE White	7 MARR	NEVER MARRIED DIVORCED		October		.882	9. AGE (In year lost birthday		oths Doys		Min
100 USUAL OCCUPATION during most of work Guard at p	ing life, even if retired	ione 10b.	KIND OF BUSINESS OR	INDU:		ACE (Stote of				Unite		COUNTRY tes
13. FATHER'S NAME Henry Huls	eman				Louise							
1S. WAS DECEASED EVER	R IN U. S. ARMED FOR If yes, give war or doles of s	MAICE)	social security no. Inknown	1	nformant cords o	f Spri	ngfie			ykesv spita		Md.
	TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o	Bro	ne for (a), (b), and (c) ] nchopneumor	nia						10	TERVAL BE ISET AND 5 day	DEATH
Canditions, if ar gove rise to in cause (a), stating t lying couse last.	y, which ) (b	Ar	terioscler	otic	heart (	diseas	e	<u>.</u>			years	
			ontributing to DEAT arterioscle						GIVEN IN	PART 1(o)	PERFO	AUTOPSY PRMED?
	S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	20b DES	CRIBE HOW INJURY OC	CURRE	D (Enter nature a	if injury in P	art I or Por	t II of item 1B]				
20c. TIME OF INJURY Hour a.m. p. m	Month, Day, Yes	While	NJURY OCCURRED Not white		ACE OF INJURY ( clary, street, office			or lawn)		(County	')	(State)
21. I certify the olive onJan	-/	decease , 19	10	death		3:00	AM, from	m the cause: treet, city or to-	s and c	on the d	ate state	
- //	Agustin de	1 Cam	/			ville			L. U.S.L.		da/-6	ire. In St. mark St.
270. BURIAL CREMATION REMOVAL (Specify) Burial		r 1958	22c. NAME OF CEMET		R CREMATORY			TION (City, tow imore,			(Stote	e)
23. FUNERAL DIRECTOR:		1103	ADDRESS S. Wolfe St		et	24a, REC'E	JAN 2	TRAR 245. RE		y signati	URE /	



BUREAU V. R.

Not while of work

ACTUAL SIGNATURE

at work 21. I certify that I attended the deceased from

1957, that I last saw the deceased and that death occurred at Alle M. from the causes and an the date stated above.

PHYSICIAN'S NAME (Type)

220 BURIAL CREMATION, REMOYAL (Specify) Burial

226. BATE THEREOF /58

22c. NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cemetery

22d. LOCATION (City, fown, or county)

(Stote)

DATE SIGNED

23 FUNERAL DIRECTOR'S SIGNATURE

**ADDRESS** 

Littlestown, Pa.

24a, REC'D BY REGISTRAR

Littlestown, Adams Co.

0

VS A15 (4)

ADDRESS (Street, city or town) state)

24b. REGISTRAR'S SIGNATURE

IN PACIFIE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU W. E.

CL DE NAU

DECEDACE

the state

			51	6 CERT	IFIC/	ATE OF I	DEATH			Reg. Dist.		510
	PLACE OF DEATH a. COUNTY	Carroll		MAR	YLAND	- CTATE	DENCE (Who		ved. If institution b. COUNTY	n: Residence Howar	before odm	issian)
	RURAL and give a	(If outside carporate limi neorest town) VILLE	ts, write	c. LENGTH OF STA	Y IN 16	-		itside corporate	inits, write RU	JRAL and giv	e nearest to	wn)
-		n Nursing				d. STREET		. Spri	ngs		ON	SIDENCE A FARM?
	NAME OF DECEASED (Type or print)	Fid LAU		Middl	_	KELLEY	ist	4. DATE OF DEATH	Jan		Day 5	Year 19 5 2
f	emale	6. COLOR OR RACE White	WIDOWI	DIVORC	ED 🔲		-1882		AGE (in years last believe)  2 yrs.	Months O	YEAR IF UNI	
100	during most of wa	ON (Give kind of work rking life, even if retired LONE	done 10b.	KIND OF BUSINESS	OR INDU		Arylar		try)		S.	T COUNTRY?
13.	FATHER'S NAME	Jeremiah	Kel	ley		Mare	s maiden n garet	Bural	1			
1\$. (Ye	WAS DECEASEDEV s. no. or unknown) NO	ER IN U. S. ARMED FOR (If yes, give war or dates of a		SOCIAL SECURITY N		nformant PS. Lll	7a Pic	eke <b>t</b> t,	Addr Mt.		Md.	
		ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o		refer (a), (b), and (c)	- Marriago	t, cra	eney S	Winne	Loses,		INTERVAL I	
	Conditions, if	DUE TO		enselva	es s	emul	yel,	derke	ho me	N. Res.	193	sof
	gove rise to couse (o), stoting lying couse last	the under-	Cirel	- 4		stron.	-				173	18
CERTIFICATION	^	THER SIGNIFICANT CON								EN IN PART 1	PERF	ORMED?
	(IF ETHEK, NOTIF	AS UNDERLYING AS UNDERLYING AS CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOW INJURY O					·			
MEDICAL	Hour a. j p. m.	RY Month, Day, Ye	While of worl	Not while at work	20e. PL	ACE OF INJURY office	(Home, farm, e bidg., etc.)	20f. (City or	town)	(Co	unty)	(Stote)
	21. I certify t	hat I attended the	decease , 12 <u>-\$</u>	20 11 OIII	<i>≤</i> 24 t death	occurred at		M, from t	, 19 <i>5</i> 8 he causes a	,that I la	st saw the	e deceased ted above.
	ACTUAL SIGNATURE	Howar	12	Hall		M.D			t, city or town, s			PATE SIGNED
	PHYSICIAN'S NAME (Type)		Е. Н/	IL		***		9			0	
	REMOVAL Specify			Poplar				Howar	N (City, tawn, o	r county) [lary]	Land (\$1	ote)
23.	C. M.	Waltz,	Wij	ADDRESS	ary	land	240. REC'D	8 158	W- ( )	TRAR'S SIGN	ÁTURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00511 **CERTIFICATE OF DEATH** Rea. Dist. No. Mil. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Filed a. COUNTY b. COUNTY MARYLAND Carroll Marvland Balto.City b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give regrest town) 2vrs.9mos.20days Sykesville Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 502 W. 37th St., Zone 11 Springfield State Hospital YES NO TO NAME OF Middle Year DECEASED 19 58 (Type or print) Dorothy Emma Emlet KRAUSSE DEATH January 10 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS lgst birthdoy) Months DIVORCED | Female White WIDOWED [7] April 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? Pennsylvania U.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Jacob Emlet Emma Kauh 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address Springfield Hospital Records Νo 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Days DUE TO gned by permit. Conditions, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN BART 1(1) 19. WAS AUTOPSY 5. 2850C121CO WITH CITE OF PERFORMED? YES [ NO Te with psychotic reaction. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Country) (Stote) 0. (). factory, street, office bldg., etc.) Not while at wark of work 21. I certify that I attended the deceased from March 20, ..., 1955, to January 10., 1958, that I last saw the deceased , and that death occurred at 8:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Springfield State Hospital PHYSICIAN'S NAME (Type) Sykesville, Maryland Walther H. Sonnenfeldt. M.D. 220. BUHAL, CREMATION, 226 DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d tOCATION [City, town or county] 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. RECID BY REGISTRAR 245\_REGISTRAR'S SIGNATUR DATE

SALVE

DECEDAED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 518 CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

00512 Reg. Dist. No

											B 111	11441		
1, PLACE OF DEATH	rroll			MARYI	AND	2. USUAL RES o. STATE	Maryl		d lived. If Institution by COUN!	TY .	esidence		odmissi	on)
b CITY OR TOWN (I	f outside carparate lim	its, write	c LENG	OTH OF STAY I	N 1b	c. CITY OR	TOWN (If o	utside corpo	orate limits, write	RURAL	ond giv	e near	est fown	) 10
Sykesvill	rarest lawn) A		Kvrs	.2mos.	2045	vs M	t. Lak	e Par	k	1	15			
d NAME OF HOSPIT	AL (If not in hospital, )	iva sireel				d STREET		0 101	45				IS RESI	DENCE
	ld State H	ospii	tal				-							NO TO
3. NAME OF DECEASED	Fi			Middle		Lo	isf	4. DATE	м	lanth		Day	Y	ear .
(Type or print)	El	izabe	eth			MORG	AN	DEATH	Jai	nuar	y 20	5,	1	1958
5. SEX	6. COLOR OR RACE	7. MAR	RIED 🔲 I	VEVER MARRIE	OLE I	8. DATE OF BIRT	ГН		9. AGE (In year last birthday	_				R 24 HRS
Female	White	WIDOW	ED 🗆	DIVORCED		Unkno	WY		75 ? Y		inths D	lays	Haurs	Min,
100 USUAL OCCUPATIO	N (Give kind of work	dane 10b	KIND O	BUSINESS OF	INDU	STRY 11 BIRTHP	LACE (State	ar lareign c	ountry)	ī	2. CITIZ	EN OF	WHAT	COUNTRY
Cook	ing lile, even if relired	)		-		Mar	yland				U_S	S.A.		
13 FATHER'S NAME						14 MOTHER	· · · · · · · · · · · · · · · · · · ·	AME				9 4 6 1		
Clinton M	organ					Marc	y E. S	Saunde	rs					
15 WAS DECEASED EVE	R IN U. S ARMED FOR		SOCIAL	SECURITY NO	17 h	NFORMANT				ddress				
No of unknown)	If yes, give wor or dates of s	ervice]			S	pringfi	eld St	ate H	ospital					
	TH [Enter only one co	J	ine for fol	(b) and (c) ?		h		7.00 11	0002002			INTER	VAL BET	WEEN
	TH WAS CAUSED BY				0.24	tord acal	amati.	0070	li ottocati	Jan		ONSE	TAND	DEATH
111124	IMMEDIATE CAUSE (		Aber				erour	3 Carc	liovascu	Tar		76	ars	-
443×	DUE TO	)		Q.	ise	sse								
Conditions, if or	mmediate [	)												
cause (a), stating the last.	the under-	)												
	IER SIGNIFICANT CON	HOLTIONS	CONTRIB	ITING TO DEA	THE BLIT	NOT BELATED T	O THE TERMIN	NIAI DIECAC	CONDITION O	PINGEN H	NI DADT I	/-> 10	1A/A5 A	LITOPSV
Psychosi	s with cer	ebra.	lart	erlosc.	lerc	Sis.	O THE TERMIN	INAL DISEAS	ic condition (	SIACIA II	IN EMKI		PERFO	RMED?
D ACCIDING W	e internionie (1)	200 00	COIDE NO	MA INTUINA OF	CURRE	D. (Enler nature	- C - T E	) 1 O	A.D. al. Days 10.3				YES 🗌	NOT
PART II. OTH PSychosi  200 ACCIDENT WAR OR CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER)	200. DE:	SCHIBE NC	AN INDIAL OF	.CURKE	D. (Chier nature	ar injury in r	011 1 01 701	I to di mensi mali					
		1001			00. 04	ter ar thillips	11.1 6	000 10						
ZOC. TIME OF INJUR Hour a. m.		ar 20d. While	NJURY O	t while	fa	ACE OF INJURY clary, street, affic	intome, form to bldg., etc.	, i 201. (City ) }	y or town)		(Co	unty)		(State)
	19		rk 🔲 at					<u>i                                      </u>						
21. E certify_th	at I attended the	decea												
alive on_Ja	nuary 26,	, 12	8	, and that	death	accurred at	6:30	PM, from	n the causes	and	on the	date	state	d abav
	7.	1	, 0	0	/			ADDRESS (S	treet, city or taw	n, stale	)		DA	TE SIGNE
ACTUAL G	wellen	de	4	ruf	20	M.D. Spr	ingile	ld St	ate Hosp	oita	ıI.		1/	27/58
MANGENCIA AUG. VA	4.4 3 30	2	2.073											
PHYSICIAN'S A	gustin del	Jampo	, MC	) 4		Syk	esvill	e, Ma	ryland	·				
220. BURIAL, CREMATIO				AME OF CEME					TION (City, lawr				(State	-)
Ber Tallecia	1/29/19	358	Ple	asant	Va	lley C	em.	near	Mt. La	ake	Pa	rk,	I.d	•
23. FUNERAL DIRECTOR	S SIGNATURE	1.3	AD	ODRESS		1 : 40 1	24a. REC'I	BY REGIST	TRAR 245 RE	GISTRAI	R'S SIGN	LATURE		
Leighton	N Flexical	de	Me,	. oakl	CINI	X 7/1/1	DATE A	137/	58 (1)	را بال	edu	ch		
		7					-/							

ENTERN N. E.

17 re----

		MARY	LAND S	STATE DEPARTM	NENT OF HEALTH	H-BALTIMORE	, 18
		;	519	CERTIFIC	ATE OF DEATH	-	Reg. Dist. No.
7 814	ACE OF DEATH				To USUAL DECIDENCE ON		
g. (	COUNTY			MARYLAND	o. STATE Maryl	- 1	utution: Residence before odinii
b. (		rroll if autside carporate limi	its write !	c. LENGTH OF STAY IN 16	1		
U.	RURAL and give no	earest lown)	iis, wille		Taneyt	*	te RURAL and give riearest tow
al		Y TOWN "AL (If not in hospitol, g		3 years	1	OWII	
0,	OR INSTITUTION	AC (IT NOT IN NOSPIIOI, E	Bive street do	acress	d. STREET ADDRESS		e. IS RE ON YES
3 NA	CEASED	Fi		Middle	Lost	4. DATE	Month Day
(Ту	rpe or print)	Clars		Floria	Peters	DEATH Jan	uary 18,
5. SEX	K .	6. COLOR OR RACE	7 MARRIE	DE NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In yellost birthdo	OF IF UNDER LYEAR IF UND
	male	White	WIDOWED		Jan. 22, 19	21 36	yrs. Months Days Hours
10a U	JSUAL OCCUPATION  Suring most of work	ON (Give kind of work king life, even if retired	done 10b. Ki	IND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote		12 CITIZEN OF WHA
	Housewi		<u></u>		Hagersto	wn, Maryla	nd U.S.A.
13. FA	THER'S NAME				14. MOTHER'S MAIDEN N	NAME	
	W1	lliam O.	Peter	្ន	Eleanor	Ovelman	
15. W.	AS DECEASED EVE	R IN U. S. ARMED FOR	RCES? 16, 50		INFORMANT		Address
4.4.4	No	in her flate mor or mores or i	214	4-14-6373	Clarence	H. T. 1.	Taneyto Marylan
18	CAUSE OF DEA	TH [Enter only one co	ouse per line	for (o), (b), and (c).]	/		INTERVAL B
	PART I. DEA	TH WAS CAUSED BY:	Do	vacens of	Brain 1	Blinder	Taring ONSET AND
	1730	DUE TO		6		o the plant	
	Conditions, if a	nu which t					
	gave rise to i	mmediate (	,				
	tause (o), stoling lying cause last.	he under-	-1				
_ =		LER SIGNIFICANT CON	IDITIONS CO	NTRIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMI	INAL DISEASE CONDITION	GIVEN IN PART 1(0) 19. WAS
CERTIFICATION	3/ NY 7	solution	True	elitus			PERFO YES [
E 20	Ou. ACCIDENT WA	S UNDERLYING			ED. (Enter noture of injury in I	Port 1 or Port II of item 18.1	
	R CONTRIBUTING	CAUSE OF DEATH MEDICAL EXAMINER)			and familia hardra di trilary in i	, , , , , , , , , , , , , , , , , , , ,	
	c. TIME OF INJUR		or 20d INI	URY OCCURRED 20e. PI	LACE OF INJURY (Hame, farm	206 (City or town)	10
MEDICAL	Hour o. j.,	19	While	Not while fo	ictory, street, office bldg., etc.	.) ;	(County)
× –	p. m.	.,,	of work	of work 3/4	7.4		(-:
2	1. I certify th	at I attended the	deceased		7, 19.35, to/		25, that I last saw the
a	live an/_	1-21	, 12.2.	and that death	n occurred at 71521	arthetaM, fram the cause	s and an the date stat
	CTIAL	16.5	nacil	4 1	INW	ADDRESS (Street, city or to	wn, slote)
Si	CTUAL IGNATURE	11.	V - V	accopy	M.D. 47 + Ma	week It.	(aucylowe
PI	HYSICIAN'S IAME (Type)	R.S	· Ma	Vaugh			0 '
	URIAL, CREMATIO	N. 226. DATE THEREC	OF I	22c. NAME OF CEMETERY C	OF CREATONY	22d. LOCATION (City, Iow	
46V . D		1 1					~ 23 ~
	EMOVAL (Specify)	1 1/91/14	GMH I	KAVSVIIIA	Mening Not A		COMMALIA
R	Burial	T\ST\T	958	Keysville		Keysville,	Carroll Co
R		T\ST\T		ADDRESS Emmitsburg	24g. REC'	D BY REGISTRAR 24b, RI	Carroll Co

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUT AL DIRECTOR: After this certificate has been signed by the attending physician and campletely at in by the funeral director, page mould be detached for use as the burial-transit permit. Then please remave carbon papers. Pour and 2 should be filled with the registrar prior to burial, crematian, or remaval, and in any event within 72 hours after death.

R. V UALAUS

C'D! IS NAI

Min now all of

HOSPITAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

\*\* A C T 113

·

pth qua

VS A15 (4) 15M 9/55 \*

		MARYI	LAND	STATE DEP	ARTM	ENT C	F HEALT	H-BA	LTIMORE,	18			
			52	1 CERT	IFIC	ATE C	F DEAT	H		Reg.	Dist. No	105	15
1.	PLACE OF DEATH	roll		MAR	YLAND	2. USUA o. STA	RESIDENCE (W	here decease	ed lived. If institu b. COUNT		dence befo timor		
	b. CITY OR TOWN (I RURAL and give no Sykesville			c. LENGTH OF STATE		c. CIT			orote limits, write	RURAL or	nd give ried	prest town	n)
	Springfi	eld State l	lve street o	tal.		2 <b>91</b> 0	Reister:	stown	Road				SIDENCE L FARM? NO 🔼
3.	NAME OF DECEASED (Type or print)	Marth:	a	Middl		Phill	last ips	4. DATE OF DEATH		onth Jan	19	,	Yeor 1958
	sex Female	6. COLOR OR RACE White	WIDOWE	DIVORC	ED 🗌		12-1891		9. AGE (In year last birthday) 67 yr	Month	DOYS	Hours	ER 24 HPS.
lo	usewife	ON (Give kind of work of ting life, even if retired	done 10b.	HOME	OR INDU	P€	nnsylva	nia	country)		S.A.		COUNTRY
		rge Wicox					Mary		•				
(%		RIN U.S. ARMED FOR		Mak	.	nforman Hospit	al reco	rds	Ad	idress			
	PART I. DEA	TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Car wit	e for (o), (b), ond (c) cinoma of h metastas	the					n	INT ONS INC	ERVAL BE SET AND ON THE	TWEEN
	gove rise to it couse (o), stoting lying couse lost.	the under-	Art	erioscler								ars	
CERTIFICATION		ER SIGNIFICANT CON PESSIVE PS								IVEN IN P	ART 1(o) 1	9 WAS PERFO YES [3]	AUTOPSY PRMED?
	IN ETHER, NOTIFY	MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY O	OCCURRE	D. (Enter no	ture of injury in	Port 1 or Po	rt II of ilem 18)				
MEDICAL	20c. TIME OF INJUR Haur a. fi. p. m.	Y Month, Day, Yea	While	IJURY OCCURRED Not while of work	20e. PL. for	ACE OF IN. clory, street	URY (Home, farn office bldg., etc	n, 20f. (Cit	y or town)		(County)		(Stote)
	actual signature	at I altended the	125	el Gun	8 death	, , ,		ADDRESS (S	m the causes Street, city or town ate Hospi	and an	t last so	te state	deceased ed abave ATE SIGNED 1 19-5
1	BURIAL, CREMATIO REMOVAL (Specify)	1-22-	58	22c. NAME OF CEN	METERY O	R CREMATO	RY	22d. LOCA	TION City, town	or county	m	(Slot	e)
23.	FUNERAL DIRECTOR	S SIGNATURE	4.6	Justiser.	lle,	Mr.	24a. REC	D BY REGIS	TRAR 246 REG	SISTRAR'S	SIGNATUR	RE	

ENURYN A' B.

00516

<u> </u>													Keg. D	31. 140.		
	PLACE OF DEATH						2. L	SUAL RESIDENCE.	E (Wh	ere decease			on Resider	ice befo	re admis	sion)
L		arroll			MARY	LAND		· · ·	iary	land	ь	COUNTY	Ba	lto.	City	7 u
	b. CITY OR TOWN (II RURAL and give no	foutside corporate limi	ts, wrile	c. LENC	TH OF STAY	IN 1b	(	CITY OR TOW	N (If o	utude corpo	prote limits	, write Ri	URAL ond	give riec	rest fow	n)
L	Sykesvil	le			10. 8 d	lays		Balti	Lmor	e				71/^	1 -	1
	d. NAME OF HOSPIT OR INSTITUTION	At {If not in hospital, ç	ive street	oddress)				d. STREET ADDRI	ESS						e. IS RES	SIDENCE A FARM?
L	Springfi	eld State	Hosp	ital				133 N.	, Co	lling	ton 1	Ave.				NO [3
3.	NAME OF DECEASED	Pi	*-		Middle			Last		4. DATE		Mon		Do	y	Yeor
L	(Type or print)		exan				JKO	VSKI		DEATH	•	Janua	ary	5,		1958
5.	SEX	6. COLOR OR RACE	7. MAR	RIED N	NEVER MARRIE	ED 🔲		TE OF BIRTH	- 0-		9. AGE (	In yeors	Months	Doys	IF UND	ER 24 HRS
L	Male	White	WIDOW		DIVORCE			ug. 15,		-		rthdoy) yrs	Months	Doys	Hours	Min.
100	anting most of work	IN (Give kind of work- ing life, even if retired	done 10b.	KIND OF	BUSINESS O	R INDU	STRY			or foreign c	ountry)					COUNT
_	Laborer							Polar						U.S.	A.	
13.	FATHER'S NAME						14.	MOTHER'S MAI		AME						
L	Unknown							Unknow	m							
15.  Ye	WAS DECEASED EVEI	R IN U.S. ARMED FOR It yes, give war or dates of t	CES? 16	SOCIAL S	SECURITY NO.		NFOR		**		n	Addr	<b>ess</b>			
L		-			-		)FL	ngfield	пов	birar	. nec	oras				
		TH [Enter only one co												INTE	RVAL BE	ETWEEN DEATH
	PARI I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	A:	rteri	oscler	otic	Ç	ardiovas	cul	ar di	sea se				ears	
	422.1	DUE TO														
	Conditions, if as gave rise to is		<u>. G</u>	mera	lized	arte	ric	scleros	is.					Y	ears	5
	couse (o), stoting (															
,	lying couse lost.	) {c	)													
õ	C.B.S. as	ER SIGNIFICANT CON	1th	ceret	TING TO DEA	teri	LOS	Clerosia	TERMIN	ALCHEAS	sych	OFTC	EN IN PAR	T I(o) I	PERFO	AUTOPSY DRMED?
FICA	7	eaction.														NO 🗌
CERTIFICATIO	OR CONTRIBUTING	CAUSE OF DEATH MEDICAL EXAMINERS	200. DES	CKIBE HO	M INTURA OF	CCURRE	). (En1	er noture of inju	iry in P	ort 1 or Par	Ill of item	1 IB.)				
	20c. TIME OF INJURY		or 20d I	NJURY O	CHIRRED	20e. PL/	ACE O	F INJURY (Home	form	20E (CIN	e ne town)			County)		(State
MEBICAL	Hour a. j.,	19	While		while	Fac	fory,	dreet, office bldg	g., efc.)	1	or iowiti		ţ,	Coomyj		121016
5	p. m.					Jan and	07	57	Ton		2	70				
		at I attended the	decea:	ed fran CR	TIOVE	per.	-61	19 <u>.2.L.,</u> to و	OOE	uary	23,	19.29	_,that I	last sa	w the	deceas
	alive an <u>Jan</u>	uary 5,	0 /	20	and that	death	, OCC	urred at 8						he dat		
	ACTUAL NI	Wall of	IR	1111	PANA	Alla		Springi		DDRESS (SI	,		,		7 //	ATE SIGN
	SIGNATURE / / C	1011005 07	· * V	111	120140	104	M.D.	phi Tue	. 161	u 502	110	OSDI			11	7/ 50
_	PHYSICIAN'S NAME (Type)	Walther H.	Son	nenfe	eldt,	M.D.	•	Sykesvi	ille	, Mar	ylan	đ				
224	REMOVAL (Specify)	206. DATE THEREC	In C	1 /	AME OF CEME	TERY O		1 /h.		nd rock					(\$101	e)
23/	FUNERAL DIRECTORS	SIGNATURE	7 0	AD	DRESS (7)	XIC	ar		DEC D	NO DECISION		n rate	TRAR'S SI	NATION	c	
1	tredu	1103 030	win	219	90 %	ast	es			8Y REGIST			- edu		E.	
=		////		/`				DAT	E							

z vy unzim

Jet 8 NAI

PAISSING

within

ā

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

By War III

TAMES OF THE

ARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 11	ARYLAND	STATE DEPARTMENT	OF HEALTH—BALTIMORE,	18
--------------------------------------------------	---------	------------------	----------------------	----

525 CERTIFICATE OF DEATH Reg. Dist. No 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived 11 institution; Residence before admission) e. COUNTY b. COUNTY Carroll MARYLAND Marvland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) RURAL and give nearest lown) Sykesville Baltimore 24. Maryland d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE OR INSTITUTION ON A FARM? Springfield State Hospital 540 Leigh Street YES NO TO NAME OF 4. DATE Middle Month Day Yeor DECEASED 19 58 DEATH (Type or print) Wilhelmia January Agnes Rader 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last pirthdoy) Days WIDOWED 17 DIVORCED [7] Jan. li. White Female 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? Housewife Home U-S-A-Germany 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME William Felters Unknown 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address Springfield Hospital Records No None 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia Davs DUE TO Cardio-vascular-renal disease Conditions, if any, which Years gave rise to immediate DUE TO cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis PERFORMED? YES NO TO with psychotic roact200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20c TIME OF INJURY Month, Day, Your 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) Hour o m factory, street, office bldg., etc.) While Not while at work at work 21. I certify that I attended the deceased from Aug. 28 1956, to Jan. 21 1958 that I last saw the deceased 19.58 , and that death accurred at 3:00AM, from the causes and an the date stated above. ACTUAL NAME (Type) 22a. BURIAL, CREMATION, 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION IC ty, town, or county) (Stole)

240 REE'D BY REGISTRAR

DATE AN 2

THE RVIENE

SPEL PR NAI

BECEINE

		MARYLAND STATE DEPARTME	INT OF HEALTH—BALTIMORE,	18
	L	4.7.3 CERTIFICA	TE OF DEATH	Reg. Dist. No. ()52()
	1.	PLACE OF DEATH  CARROLL  MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institute o. STATE A PUI A 10	
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  WESTMINSTER  7 VEARS	c. CITY OR TOWN (If outside corporate limits, write	RURAL and give nearest town)
		d NAME OF HOSP TAL (If not in hospital, give street oddress) OR INSTITUTION COURT PLACE	d. STREET ADDRESS  COURT PLACE	e. IS RESIDENCE ON A FARM? YES NO A
	3.	NAME OF First Middle DECEASED (Type or print) WILFORD FRANKLIN R	Lost 4. DATE Mo	1001111
	S.		DATE OF BIRTH  OCT 24 /885 77 yrs	
leath		USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRI during most of working life, even if retired)  AND EIFCTRIC CO ENGINEER	1/100- 12	12 CITIZEN OF WHAT COUNT
offer I	1	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	1 Disella
2 hours	15 {Ye	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INF (If yes, give wor or doles of service) 2/2-05-660 4 Ma	FORMANT Add	Iress W.T.
vithin 7	-	18. CAUSE OF DEATH [Enfer only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY:	CO. MARY LRAID INAIC	INTERVAL BETWEEN ONSET AND DEATH
event		7440 DUE TO	E HEART FAILURE	24 How
d in any		gove rise to immediate cosse (a), stating the <u>under</u>	ENIA GRAVIS	
aval, an	CATIO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N	NOT RELATED TO THE TERMINAL DISEASE CONDITION GI	VEN IN PART I(o) 19 WAS AUTOPS' PERFORMED? YES NO
po Territoria	CERTIF!	20g ACC DENT WAS UNDERLYING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter nature of injury in Part 1 or Part II of item 18.)	
emation	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 While Not while of work of other of the other p. m. 19 Not work of the other p. m.	CE OF INJURY (Home, form, 20f. (City or town) ary, street, office bldg., etc.)	(County) (State
urial, cr		21. I certify that I offended the deceased from JAN, 16, alive on JAN, 16, 1258, and that death of	occurred at 1,45 F.M., from the couses	
riar ta b		ACTUAL SIGNATURE Daniel & Wellier, M.	ADDRESS (Sireet, city or town, D. CHURCH ST. WESTMIN	stote) DATE SIGN
is rar p		PHYSICIAN'S DANIEL I. WELLIVER	, WESTMINSTER	Mch
	22	BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR	EREMATORY 22d LOCATION (City, town,	or county) (State)
the reg	Z	FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24g RECO BY REGISTRAR 24b. REG	STRAR'S SIGNATURE

BUREAU V. S.

ESEL IS NAI

Marie

VS A15 (4) 15M 9/55 I

526	CERTIFICATE	OF	<b>DEATH</b>

. 00521

1.	PLACE OF DEATH	roll		MARYL	AND	2. USUAL RESII o. STATE	D <b>ence</b> (Wh Maryl		b, COUNTY			odmissi	ion)
	b. CITY OR TOWN (II RURAL and give ne	Foutside corporate limitarest town)	ts, write	C LENGTH OF STAY II	N 16				rote limits, write R			est town	1
_	· · · · · · · · · · · · · · · · · · ·	esville		7mo, 5dy				ATTTE	(rural)	near (			
	OR INSTITUTION	AL (If not in hospitol, 9 ingfield S	tate	Hospital		/d STREET A		3, B	ox 234		•		DENCE FARM? NO 🔀
3.	NAME OF DECEASED (Type or print)	Lo	ttie	Middle Genev	⁄a.	Rand		4. DATE OF DEATH	Janu		22		958
5.	SEX F	6. COLOR OR RACE	7 MARR	DIVORCED	ן וייי	B. DATE OF BIRTH December		1883	9. AGE (In years lost by thday)	Months	Days	Hours	R 24 HRS Mis
100	. USUAL OCCUPATIO	N (Give kind of work ing life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUS	TRY 11. BIRTHPL	ACF (Stole	or foreign c		12 CIT	ZEN OF	WHAT	COUNTRY?
L	Housewif			Home			Maryl	and		US	A		
13.	Joshua B	0.00000				14. MOTHER'S							
			1				Georg	eanna	40 10				
15. [Ye	was deceased ever	R IN U.S. ARMED FOR	CES? 16 :	SOCIAL SECURITY NO	17. IN	IFORMANT Same	inati	പി വ	Addi				
L						- opr	Tugit	era no	spital r	ecora	3		
	1	TH {Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o	Caro	dio-respira	tory	y insuff	icien	су			ONSE	hour	DEATH
	4.731	DUE TO											
	Conditions, if or			umonia								day	
	gave rise to in couse (o), stating t												
~	lying couse lost.	) (c	)										
CATION	sclerosis	lated with with psyc	circu choti	ONTRIBUTING TO DEAL Latory dis Creaction	tur	oance, w	ith co	ore bra	condition GIV 1 arteri	O-		PERFO	RMED?
CERTIF	20a ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING A CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OC	CURRED	(Enter noture of	f injury in F	ori 1 or Port	(I of item 1B.)				
MEDICAL	20c. TIME OF INJURY Hour o.m. p. m.	Month, Day, Yes	While	NOI while of work	lOe. PLA Foci	CE OF INJURY (I lory, street, office	s bldg., etc.				ounty)		(State)
	21. I certify the	ot I offended the January 22	decease	3	17,	1957	11:25		y 22 <sub>19</sub> 58				
	GHVE OH		, 17	, and that a	eoin	occurred at.			n the causes a reet, city or town, .		e date		d abave. TE SIGNED
	SIGNATURE - 12	Full Stull	el/10.	"at H.D. Son	ulg	Noid Sta	he ling	octal	Sylvisia	. 4	/, 1	,	,
	PHYSICIAN'S SOA	KENFELDE	Gert	Jud Spri	ustie	a Stole	Horas	ifa [	Sykisich	Ci lua	/ ,		
220	BURIAL, CREMATION	N, 226. DATE THEREC	F ₹	22c NAME OF CEMET	ERY OR	CREMATORY		228 LOCAT	TON (City, town, o	r county)		(Stote	)
	<u>surial</u>	1-25-19	58	Lorraine	Ce	metery		Balti		aryla			
_	FUNERAL DIRECTOR'S			ADDRESS				BY REGIST	RAR 246 REGIS	TRAR'S SIG	MATURE		
E	LLSWORT	TH ARMAC	OST	4600 Libe:	rtv	Heights	DATEAN	2 / '58	W. A.	eaut	K		

ाडे पाडे श्री

BUREAU V. S.

				1
	F	0	R	\$1
h	E	A	LŢ	H
within 24 hours after denth. If may delay is necessary, mean	a Nem, 18. Give Pages 1, 2, and 3 to the funeral director. Page min.	along with form PM3. Page 5 may to ained for your files.	it permit. File pages 1 and 2 withlote Board of Health, 1	al, and in any event within 72-haurs after death.
KR: This certificate should in many	miting the word "pending" in pencil in I	Chief Medical Examiner's Office of	age 3 shauld be used as a buriol-transi	berial, cremation, ar remove
EPUTY MEDICAL EXAMIN	cry's the certificate, writing	the forworded to the	RAL DIRECTOR: Page	its designated agent, prior to

VS. A15ME 5M 2/57

E	Reg. Dist. No.				
T. 1,	PLACE OF DEATH  O COUNTY A D D A LA S COUNTY A D D D D A LA S COUNTY A D D D D D D D D D D D D D D D D D D				
	CATTOLL MARYLAND STATE MARYLAND CARROLL				
1,	b. CITY OR TOWN   founde corporate limits write BURAL and give nearest lown)   c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest lown)				
4	UKAL TANEYIOWN YEARS RUKAL TANEYIOWN X				
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES NO				
	NAME OF DECEASED (Type or print) RICHARD ISAIAH REIFSNIDER DEATH JAN 11 19 58				
5.	SEX  6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH  WIDOWED DIVORCED JUNE 17 - 192 4  9. AGE (In 700)  Wanths Days Hours Min.				
10	On USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country)  12 CITIZEN OF WHAT COUNTRY  during most of working life, even if refired)  1 FIX AINT  11 BIRTHPLACE (Stole or foreign country)  12 CITIZEN OF WHAT COUNTRY				
13	3. FATHER'S NAME				
L	ISIAH REIFSNIDER ALICE RINEHART				
	S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address				
_	NO 219-12-2278 BETTY REIFSNIDER TANEYTOWN _ MP				
	18 CAUSE OF DEATH (Enter only one coute per line for (o), (b), and (c).)  INTERVAL STRVETS  GNSET AND DEATH				
	PART I. DEATH WAS CAUSED BY: CATBON MONOXIDE MOISONING The				
	7 / J. J DUE TO				
	Conditions, if ony, which by governse to immediate cause				
	(o), stoling the underlying DUE TO				
z					
CERTIFICATION	PRECOMED? YES NO				
MEDICAL	20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stole) Hour o. m.    Hour o. m.   / 1/ 1958 of work   of				
	21. I certify that Mook charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my				
	opinion death esulted from: Natural causes [], Accident [], Suicide [], Hamicide [], Undetermined manner []				
	ACTUAL SIGNATURE SECULLY I. Thorach M.D. CHIEF MEDICAL EXAMINER [] DATE SIGNED				
	EXAMINER'S T M ASSISTANT MEDICAL EXAMINER []				
	GAME (Type) AMES . / PRSH DEPUTY MEDICAL EXAMINERS				
22	20. BURIAL CREMATON, 226 DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Slote)				
	BURIAL 1114/58 KEFORMILD TANEYIONN MU				
23	DATE JAN 1 5 '58 Chief Line Jan 1 5 '58				
x	IN MUNICIPALITY SOUND, WHICH INCHILLED INCHILLED				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EVAMINEDIC CERTIFICATE OF DEATH

110529

JAN ALBOUR

2 .V UALACI

VS A15 (4) 15M 9/55

			STATE DEPARTM	NENT OF HEALT		TIMORE, 1	8	0052	23
	5	28	CERTIFIC	ATE OF DEAT	Н		Reg. Dist.	No.	4
PLACE OF DEATH	Carroll		MARYLAND	2 USUAL RESIDENCE (Man STATE	there deceased ryland	Flived. If institution b. COUNTY	ns Residence	before admin	sian)
b. CITY OR TOWN ( RURAL and give n	If autside corporate limits earest town) Syrkesville		c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF		rate limits, write Ru e City 12		3 V /	7
d. NAME OF HOSPI OR INSTITUTION,	TAL (If not in hospite), gi Springfield	Stat	e Hospital	d. STREET ADDRESS	Ol Pen	tridge Ro	ad	e. IS RES ON A YES	FARM?
3. NAME OF DECEASED (Type or print)	Firs Anni e	t	Middle Elizabeth	Renshaw	4. DATE OF DEATH	January		,	Year 195
5. SEX F	6. COLOR OR RACE	7 MARR	IED NEVER MARRIED DIVORCED	November 11,	1873	9. AGE (In years last birthday)		YEAR IF UNDI	ER 24 HI Min
during most of wor Housevil fe	king life, even if retired)	ane 10b.	KIND OF BUSINESS OR INDI Home	Pennsylv		ountry)		en of what ISA	COUN
John Henr	ry			14. MOTHER'S MAIDEN (Elizabet	t .	rne, Emm	а		
(Yes, no or unknown)	ER IN U. S. ARMED FORG (If yes, give war or dates of se	IES? 16.	SOCIAL SECURITY NO 17.	INFORMANT Springfi	eld Ho	Addrespital re			
	ATH [Enter only one county ATH WAS CAUSED 8Y. IMMEDIATE CAUSE (a) DUE TO	A -	ne for (a), (b), and (c) }	c heart disea	ise			INTERVAL BE	
Canditians, if a gave rise to cause (a), stating lying couse last.	Immediate DUE TO	Aı	rteriosclerosi	.8				Year	6
Cerchnal  Cerchnal  Con Accident w OR CONTRIBUTING  (IF EITHER, NOTIF)	crain syn ro arterioscle	ome a Prosi	ONTRIBUTING TO DEATH BUSSOCIATED WITE SWITH DSYCH CRIBE HOW INJURY OCCURR	n circulatory otic reaction	cistu	r ance, w	en in part i	PERFS	AUTOPS PRMED? NO [
20c. TIME OF INJU Haur a.m. p.m.	RY Manth, Day, Yea	20d. It While at warl	Nat while f	LACE OF INJURY (Home, for actory, street, affice bldg., e	m, 20f. (City	or town)	(Co.	unly)	(Sto
alive on Jan	hat I attended the way I	decease _, 19_5	ed from Septembe Se, and that deat will him, sp	r 20, 19 57, ta 1 h occurred at 1:5D	PM, from		nd an the	date stat	
ACTUAL SIGNATURE	LUMIL O O OL		•						
PHYSICIAN'S NAME (Type)	ERTRUD SC	NNE	NEELDI M	<u>, D </u>					
SIGNATURE A	1/4/58	NNE E	St. John E	OR CREMATORY . U.B. Cem.	22d, LOCA Pa	TION (City, town, a	Penn TBAR'S SIGN		nlio

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TOTAL AS E

1			MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
FOR STATE			5 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.
HEALTH DEPT	Г.	1. 7	LACE OF DEATH    2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
P. S.			LARROLL MARYLAND CARROLL
4 ままっ		b	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  and give nearest lown)
essor you d of	-	1	URAL WEST MINSTER 7 mo. JURAL WESTMINSTER X
al dur	0	d	NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  RD 4  VEST NOTE:
funer funer laine Hate			IAME OF First Middle Doy Year
ie in de			Type or print) DRIAN DARYL TICHARDS DEATH JEW 23 1958
a so		5. SI	Months Days Hours Min.
house said		10a.	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHFLACE (Stole or foreign country)  [22. CITIZEN OF WHAT COUNTRY?]
Poge on 72		d	rring most of working life, even if retired)  PA.  U. S. / S.
S S S S S S S S S S S S S S S S S S S		13.	FATHER'S NAME () 14. MOTHER'S MAIDEN NAME
Pag Pag Pag ent		_ 2	DOUGLAS) RICHARDS ANNA MAE MET
24 h Sive File File y ev		15. (Yes.	WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 SNFORMANT Address P. 17 4
· · · · · · · · · · · · · · · · · · ·			- DOUGAAS ). MICHARDS WESTMINSTER ! JO
nd in	- 1	4	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY:
ale ale			IMMEDIATE CAUSE (a) NEUMONIA
Frice Frice From Novo	/		DUE TO
Para Para Para Para Para Para Para Para	- 1		Genditions, if any, which agove rise to immediate couse (b)
in i			(a), stating the underlying DUE TO
as commercial		2	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101/19, WAS AUTOPSY
emd em		Y X	PERFORMED? YES NO W
d dip		CERTIFIC	200. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Fort H of stem 18.) CAUSE OF DEATH.
work Maria			CAUSE OF DEATH.
R: Ti The Chie I sho to b		DICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or lown) (County) (State)  Hour o, m, While Not white
ing ihe ihe		MED	p. m. 19 of work all work
AN Vrii Po 1. Po			21. I certify that I took charge of the remains described above, held on Autopsy . Inspection . Inquiry . and in my
Ged Ged Gen Gen Gen			opinion death resulted from: Natural couses X. Accident [], Suicide [], Hamicide [], Undetermined manner []
A STATE OF THE O			ACTUAL TILLES I METERS OF CHIEF MEDICAL EXAMINER (*)
MED cer cer cer cer cer cer cer cer cer cer	_		ASSISTANT MEDICAL EXAMINER []
HA P	ÇK.		EXAMINERY TAMES 1, MARSH DEPUTY MEDICAL EXAMINER W
E 3		220.	BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, Town, or county) (State)
0 40 9		B	WRIAL 11-26-1930 MEADOWDRANCH GEMINESTMINSTER! MAD.
VS A15ME	d	23. X	ONE ADDRESS 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE
5M 2,57	4	1	WHALL Wantard Westmineter, Md.   DATEJAN 2 7 '58   Cle ecuch
		1	



BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 530 CERTIFICATE OF DEATH

r this	MARYLAND STATE DEPARTMEN	NT OF HEALTH-BALTIMORE, 18						
copy of	530 CERTIFICATE	OF DEATH 00525						
third co		Reg. Dist. No						
<b>∌</b> €	1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED						
s af the	COUNTY ( ARRO// MARYLAND	STATE MARY/AND COUNTY CAPPOLL						
	C-TY (If outside corporate fimits, write RURAL   LENGTH OF STAY	CITY (If outside corporate limits, write RURAL and give nearest town!						
in in	TOWN (A) HD C+ EA D	TOWN HAMPST EAD						
16,	HOSPITAL OR INSTITUTION OR	/ STREET (If rural give location)						
within funeral	STREET ADDRESS Brodbecks Rd	ADDRESS Brod becks Pd.						
	3. NAME OF (First) (Middle)	(Lest) 4. DATE (Month) (Day) (Year)						
registrar by the	(Type or Print) (100Tha Elizabeth	Ruby DEATH, /ANUQUY Z81058						
by 1	S. SEX 6. CO.OR OR 7. SINGLE, MARRIED, 8. DATE O WIDOWED, DIVORCED,	PF BIRTH 9. AGE lest birthdey IF UNDER 1 YEAR IF UNDER 24 HRS.						
	Jenule While Specify vedoce 71/2	ency 5 1877 8 Nonth's Days Hours Min.						
-c-0	10e. USUAL OCCUPATION (Give kind of work done during most of working life, even # OR INDUSTRY	11. SIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT						
ed with y filled permit.	retired) / fauselich ) forme	may Could 19 A,						
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
W 0 W	desse Leister	SAILLE I RINE.						
ate be compl	IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.  (Yas, no_or unk.) (If Yes, give wer or deles of service)	17. INFORMANT & ADDRESS						
rtifical and co burial	NO (11 to 1, give was of colors of service)	_ IRAY E. MULLY HAMPSTEAD MY						
certificate and com burial fr	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  18. MEDICAL CERTIFICATION  INTERVAL E ONSET AN							
	· IMMEDIATE CAUSE (A) Chronic	Mungarditis						
de lysi	ANTECEDENT CAUSEISI DUE TO A	A: Or 2 11 0 12						
20 5	DISEASES OR CONDITIONS, IF ANY, (B) CLABO DA SELANT GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	be Cardy Vasadu During						
that i								
	(C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING							
requires the after s detach	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
, A	19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?						
by uld b	21a. ACCIDENT WAS UNDERLYING [3] 21b. PLACE (Home, ferm, fectory,   2	YES NO PER DID INJURY OCCUR? (City or town) (County) (Stata)						
OR: The la executed by nbly should	216. ACCIDENT WAS UNDERLYING 21b. PLACE (Home, ferm, fectory, OR CONTRIBUTING 3 CAUSE OF DEATH OF INJURY street, office bldg., etc.) 2  [IF EITHER, NOTIFY MEDICAL EXAMINER]	Cle. WHERE DID INJURY OCCUR? (City or town) (County) (Stata)						
Secu Siy	21d. TIME OF INJURY (Month) (Dey) (Year) (Hour) 21a. INJURY OCCURRED	211. HOW DID INJURY OCCUR?						
RECTOR: sen exect assembly	M. While Not white of work							
DIRECTOR: s been execuate assembly	22. I hereby certify that I attended the deceased from 1) 2010	19.J. 7, to JAN 29, 1958, that I last saw the deceased						
	alive on A.M							
Triffi No	SIGNATURE	ADDRESS (Street, city, lown, stete) DATE SIGNED						
	23. BURIAL, CREMATION, TO THE THEREOF I NAME OF CEMETERY OR	Trampoliad med 1/29/58						
certificate had death certificate A15C 1-55 TOM	23. PURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR	CREMATORY LOCATION (City, town, or county)						
~ ° ° ∢ ]	A4. REC'D BY REGISTRAR L REGISTRAR'S SIGNATURE	es clude et ill						
<b>1</b> vs	10N31 158 RIEL ocuel	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS TO A SULPTIME ADDRESS TO						
	BATE SAITO	well chysian 1 and 119						

EUPEAU V. A.

8291 IE NAT



531 CERTIFICATE OF DEATH

ed in by the funeral director, I and 2 should be filed with

TO HOSPITAL TRENTING THYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

DET RAL DIRECTOR: After this certificate has been signed by the attending physician and completely possible under the state of the buriot-transit permit. Then please remove carbon papers. It the registrar prior to buriot, cremation, or removal, and in any event within 72 hours, effected the

may be retained by the hospital or attending physician.

VS A15 (4) 15M 9/55 00526

		0.6	A villa						Keg. Dist	T. NO.		
١.	PLACE OF DEATH				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
	Car	rroll		MARYLAND		Maryland Baltimore						
Г	b. CITY OR TOWN (I	Foutside corporate lim	sits, write	c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
	Sykesvill	Le		9 days		Baltimore 6					X 37	
	d. NAME OF HOSPIT	'AL (If not in hospital.	Qive street	oddress)		d. STREET ADDRESS					IS RESIDENCE	
L	Springfie	eld State I	Hospi	tal		5914 Mea	dow R	oad			ES NO 🖹	
3.	NAME OF DECEASED	Fi	irst	Middle		Lost	4. DATE OF	Mar	nth	Day	Yeor	
	(Type or print) George		orge	John	SCI	HREIBER	DEATH	Janu	ary 6, 1958			
5.	5. SEX 6. COLOR OR RACE 7. MAR		7. MARI	RIED NEVER MARRIED	1	ATE OF BIRTH		9. AGE (In years last birthday)			UNDER 24 HRS.	
L	Male	White	WIDOW	ED DIVORCED		8/25/13		III yrs	Manins	Days n	laurs Min	
10	. USUAL OCCUPATIO	ON (Give kind of work	done 10b.	KIND OF BUSINESS OR IND	USTRY		ar foreign (	country)			WHAT COUNTRY	
	Hospital	orderly		-		Maryland			U.	S.A.	)	
13.	FATHER'S NAME				1.	I. MOTHER'S MAIDEN N						
	Christian	1 Schreiber	r			Agnes Cha	apman					
15 (Y	WAS DECEASED EVE	R IN U. S ARMED FOI	· non-newl			RMANT		Add				
L	NO NO	-		216-18-9580	Sp	ringfield H	ospit	al Record	3			
Г				ne for (a), (b), and (c).]						INTERVAL BETWEEN		
		TH WAS CAUSED BY: IMMEDIATE CAUSE (	o) No	dular cirrhos	is	of the live	r.				T.	
	581.1	DUE TO	0									
	Conditions, if a		b) Ch	ronic alcohol	ism					Years		
	gave rise to i	> DIE 7/	0									
_	lying cause lost.	,	(c)	<del> </del>								
CERTIFICATION	C.B.S. V	vith convu	lsive	disorder.	UT NO	FRELATED TO THE TERMI	NAL DISEA	SE CONDITION GI	VEN IN PART		WAS AUTOPSY PERFORMED? ES NO []	
RTIF	20g. ACCIDENT WA	S UNDERLYING DEATH MEDICAL EXAMINER)	206. DES	CRIBE HOW INJURY OCCUR	RED. (E	nter noture of injury in f	Port I or Po	rt II of item 18 )				
	(IF EITHER, NOTIFY	MEDICAL EXAMINER)										
MEDICAL	20c. TIME OF INJUR	Y Month, Day, Yo	ear 20d. 1 While			OF INJURY (Home, form, street, office bldg., etc.		y or tawn)	(C	ounty)	(State)	
MEC	p. m.	19	at wai	LAGI MILIS	,							
	21. I certify that I attended the deceased from December 27, 1957, to January 6, 1958, that I last saw the decease											
	alive an Jax	nuary 5,	, 19_	58, and that dea	th ac	curred at 3:35	A M, fra	m the causes	and an th	e date	stated above	
								DATE SIGNE				
	ACTUAL SIGNATURE	MUL 81 10	MI	nyaas	_ M.D.	Springfie	ld Ho	spital			1/6/58	
	PHYSICIAN'S NAME (Type)	alther H.	Sonne	nfeldt, M.D.		Sykesvill	e, Ma	ryland.				
22	BURIAL, CREMATIC	Jan. 9.		Oak Lawn (				tion (City, town, Ltimore		Md.	(Stote)	
-	FUNERAL DIRECTOR		-7.50	ADDRESS	ЭФЩ		D BY REGIS		STRAR'S SEG			
	HENRY SAI		ONS.	INC. Baltimo	re	Md. PATELA	N 8	8. Chi	TE COLUMN	CRUN		

OBINESSED ES

00527

(State)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No. 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) c. CfTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO Month IF UNDER 1 YEAR IF UNDER 24 HRS Months Davs Haurs 12 CITIZEN OF WHAT COUNTRY?

Address

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 101 19, WAS AUTOPSY PERFORMED? YES NO |

(County)

T, that I last saw the deceased \_, and that death occurred at 4/30 N. M. from the causes and on the date stated above ADORESS (Street, city or fgwn, state

(State) SMOVAL (Specify) FUNERAL-DIRECTOR'S SIGNATURE

VS A15 (4) 15M 10/57



BUREAU V. L

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

filled

pluods

offending

ģ

7

P

10

V5 A15 (4)

ony

requires that the death

death;

within 24



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

A VA

8961



Reg. Dist. No.

1. PLACE OF DEA o. COUNTY	AND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE b. COUNTY Balto.City									
b. CITY OR TO	WN (If outside corporate lim	its, write	c. LENGTH OF STAY IN	V 1ь	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)						
RURAL ond give negrest town) Sykesville 6mos.19 days			vs I		Balt	imore	10.		, ,		
	IOSPITAL (If not in hospital, g	give street o			d. STREET A	DORESS	701 N	Charle	s St.	0.1	S RESIDENCE
Springt	ield State Ho	spita	1		7200	Nayy	4 1 12 00 11 1	/\B&\\A\			ES NO
3. NAME OF DECEASED (Type or print)	Fic Zea	line	Middle Emillic	в	STAUF		4. DATE OF DEATH	Jar.	nh	16,	1958
5 SEX	6. COLOR OR RACE	7. MARRI	IED NEVER MARRIED	8.	DATE OF SIRTI	1	9	. AGE (In yours	IF UNDER		UNDER 24 HRS.
Female	White	WIDOWE	D DIVORCED		Novemb	er 27	, 1863	last birthday)	Months	Days H	ours Min
during most o	JPATION (Give kind of work of working life, even if retired ther	done 10b. I	KIND OF BUSINESS OR	INDUSTI		ACE (Stole	or foreign cou	infry)		U.S.A	WHAT COUNTRY
13. FATHER'S NAM	NE .				14. MOTHER'S	MAIDEN N	IAME				
Frede	rick Stauf				C	arist:	ine Ger	hardt			
15. WAS DECEASE	DEVER IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17, INF	ORMANT			Add	Iress		
No	(If yes, give wor or dates of a	Identical]	-	5	Springf:	ield	Hospita	al Recor	ds		
	F DEATH [Enter only one co	ouse per lin	e for (o), (b), and (c) ]		IONSET A					AL BETWEEN AND DEATH	
PART	I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c	Ar	<u>teriosclero</u>	tic	heart d	<u>iseas</u>	е			Yea	
4.20.0	DUE TO	)									
	if ony, which	)									
	to immediate DUE TO	)									
lying couse											
G. B. S	LOTHER SIGNIFICANT CON BOSOC - WITH	EPILLE	ONTRIBUTING TO BEAT	H BUT N BASE	WI CHE P	sycho	PAL PISEASE	CONDITION GI	VEN IN PAR		WAS AUTOPSY PERFORMED?
	IT WAS UNDERLYING INTING IN CAUSE OF DEATH OTHER MEDICAL EXAMINER)	20b DESC	RIBE HOW INJURY OCC	CURRED.	(Enler nature of	injury in I	Port Lar Part I	l of item 18.)			
Hour o	NJURY Month, Day, Ye a. fr. a. m. 19	While	UURY OCCURRED 2 Not while of work	Oe. PLAC facto	E OF INJURY (I ry, street, office	tome, farm bldg., etc.	. 20f. (City o	er town)	(	County)	(State)
	Edmund Lust	1958 Ju	and that d	death c	occurred at.	7:15P	_M, fram ADDRESS (Stra	the causes of the city or town. te Hospi	and an t	last saw he date	the decease stated above DATE SIGNE 1/17/58
PENNOVAL ISC	AATION, 226. DATE THEREC	)F	22c. NAME OF CEMET	ERY OR O	REMATORY			ON (City, town,	or county)		(State)
Burial	Jan. 20,	1958		ark			Baltin			Md.	
73. FUNERAL DIRE John O. 1.11	ctors signature tchell & Sons	Inc.	ADDRESS 1900 Eutav	w Pla	ce	24a, REC'I	N 2 0 158	AR 245 REG	strar's si		

d in by the Tunarol director, and 2 should be filed with TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the Fath certificate be executed within 24 Bours ofter death. Page 4 moy be retained by the hospital or attending physician.

TO FUNCATE DIRECTOR: After this certificate has Team signed by the ottending physician and completely page. Thould be detached for use as the buriol-transit permit. Then please remove corban papers. Puthe registror prior to buriol, cremotion, or removal, and in any event within 72 hours ofter death.

ENHEVN A. E.

: , NAt

Man north

536 0053CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a COUNTY b. COUNTY MARYLAND CITY OR TOWN (If outside carporate limits, write E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) RURAL/and give nearest towg d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES 🗍 NO 🖺 NAME OF Middle Year DECEASED (Type or print) 9 AGE (In years IF UNDER TYEAR IF UNDER 24 HRS 5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Months Days Hours WIDOWED-100. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPUACE (State or fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 4612770634 laborer 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 20 0W2 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address 18. CAUSE OF DEATH [Enter only one couse per lane for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Ghour IMMEDIATE CAUSE (a) Canditions, if any, which gave rise to immediate **DUE TO** cause (a), stating the under-Cardio -vascula lying couse fost. PART II. OTHER SIGNIFICANT CONDITIONS NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY YES NOT 20b. DESCRIBÉ HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18.) 20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Day, Year 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, farm, 20f (City or fown) (County) (State) factory, street, office bldg, etc.) a m While Not while of work of work 21. I certify that I attended the deceased from Schot I last saw the deceased and that death occurred at /U. \_M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 22a BURIAL CREMATION, 22c MAME OF CEMETERY OR CREMATORY REMOVAL (Specify) O 23 FETNERAL DIRECTOR'S SIGNATURE 245 REGISTRAR'S SIGNATURE 24a, REC'D BY REGISTRAR VS A15 (4)

HEALTH—BALTIMORE, 18

8391 IC NAI

UB A DE SENA

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
FOR STATE		474EDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 00532
ALTH DEPT.	1	PLACE OF DEATH  COUNTY (APROLL  MARYLAND  2 USUAL RESIDENCE (Where deceased lived If institut argresidence before admission)  6 STATE / P. 6. COUNTY APROLL
of Hed	k	CITY OR TOWN (If outside corporate I mile, write RURAL and give nearest lawn)  WESTMINSTER  307PS- WESTMINSTER
ed for )		NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  32 E, MAIN  15 32 E, MAIN  15 NO C
er deat		NAME OF STREVIS DEATH JAN 27 1958
2 with 2 with tours oft	5. 5	WIDOWED DIVORCED AUG. 2, 1909 Aur buthder) yra Months Days Hours Min.
Page 1 and Nin 72 h	LE	USUAL OCCUPATION (Give kind of work done) 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country)  17 CITIZEN OF WHAT COUNTRY?  18 STOPE + AUCTION  19 SA
m PM3.	13.	THARLES V. STREVIG PAISY L. CARR
with for namy e	13.  Yes	NO 1886-09-18219 MARY V. BAIR STATE WEST/71957ER
olong sit peru		18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c)]  PART 1. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (a)  ORD NOT RY  O
office remove		Und on the part of
ion, or	7	(a), stating the underlying DUE TO cause last.  (c)
ical Ex eremai	CERTIFICATION	PERFORMED?
ould be buriol,		CAUSE OP DEATH.
the Charles as strior to	MEDICAL	Hour a. m. While Nat while factory, street, affice bldg., etc.)
TOR: Po		21. I certify that I taak charge of the remains described above, held an Autapsy, Inspection Inquiry, and in my apinion depth resulted from: Natural causes Accident, Suicide, Homicide Undetermined manner
DIREC		ACTUAL SIGNATURE AND CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSI
rs design	720	EXAMINER'S AMEST. MARSH DEPUTY MEDICAL EXAMINER (A) 220 LOCATION (City, lown, or county) (State)
700	3/23	FUNERAL DIRECTORY 1-30-1958 PRIDERS OF FORMED CEM WESTMINSTER CONTROL ADDRESS 240. REC'D BY REGISTRAR'S SIGNATURE
5ME , \$7	X	David Wishminells, 1967. DATE MAN 3 1 '58 Old Lebuch



ofter death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TA THE

9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

DECENSED

MARYLAND	<b>STATE DEPARTMENT</b>	OF	HEALTH-BALTIMORE,	18
539	CERTIFICATE	OF	DEATH	

(10535 Reg. Dist. No. 74

	1 PLACE OF DEATH 0 COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, If institution: Residence before adm 0. STATE Maryland b. COUNTY								lmission)		
	b. CITY OR TOWN (I RURAL and give n TIET)	f autide carparate limi agrest town) Py CON.	ls, write	c. LENGTH OF STAY	уs ys	c. CITY OR TOWN (II Mc D		orote limits, write R Maryla	_	ve negrest	lown)
	d. NAME OF HOSPIT OR INSTITUTION	At (If not in hospital, of Henry ton		te Hospi	tal	d. STREET ADDRESS				0	RESIDENCE N A FARM?
	3. NAME OF DECEASED (Type or print)	George		Middle Dewey		Turner	4. DATE OF DEATH	Januar		13	Yeor 19 58
1	Male Male	6. COLOR OR RACE Negro	7. MARR	IED NEVER MARRI		8. date of Birth October - ?	-1898	9. AGE (In years lost birthday)		YEAR IF U	NDER 24 HRS. Urs Min,
	100 USUAL OCCUPATION (Give kind of work dane 106 KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country)  Laborer  12. CITIZEN OF  Haryland  U.S							. S.			
	13. FATHER'S NAME					14. MOTHER'S MAIDEN	NAME				
	Albert	Turner				Maggie	Webb				
	15. WAS DECEASED EVE	R IN U. S. ARMED FOR	CE57 16.	SOCIAL SECURITY NO	17 1	NFORMANT		Add	· · · · · · · · · · · · · · · · · · ·		
	(Yes, no or unknown) NO	(If yes, give war or dates of s	nvica)	0-16-979	-1	atherine P	almer			Mar	yland
18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)]  PART 1. DEATH WAS CAUSED BY: Cardiovascular Insufficiency  OOd X  DUE TO  Conditions, if only, which gave rise to immediate couse (o), storling the under-living couse lost.  Pulmonary Tuberculosis moderately Advance (c)  [Enter only one couse post of the under-living couse lost.]							nced		L BETWEEN ND DEATH		
3	САТІС		DITIONS C	ONTR BUTING TO DE	ATH BUT	NOT RELATED TO THE TERM	MINAL DISEAS	E CONDITION GIV		PE	AS AUTOPSY RFORMED?
		S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	206 DESC	TRIBE HOW INJURY C	CCURRE	D. (Enter nature of injury in	Part I or Par	t II at item 18.)			
	20c. TIME OF INJUR	Y Manth, Day, Ye	or 20d. IN While at wark	Nat while at work	20e. PL/	ACE OF INJURY (Hame, for tary, street, affice bldg , e	m, 20f (City	y or town)	(Co	iunly)	(State)
/	ACTUAL SIGNATURE	21. I certify that I attended the deceased from April 2 , 1956 to January 13 1958, that I last saw the deceased alive on January 13, , 1950, and that death occurred at 8: UUPM, from the causes and on the date stated above.  ADDRESS (Street, city or town, state)  DATE SIGNATURE  ACTUAL SIGNATURE  M.D. Henryton, Maryland									
	NAME (Type) E  220 BURIAL, CREMATIC  REMOVAL (Specify)		F	D., Sup			and the same of	State Ho			denrytor
	23. FUNERAL DIRECTOR	your co,	1954	ADDRESS	nez	1 / 240. REC	C'D BY REGIS	TRAR 246 REGIS	Z = E ( STRAR'S SIGN	MATURE	Ld.
	J. tamble	low ta	1112-6	w DEN	luc:	allo Miphite J	IAN 1 5 1	58	1-lex his	ek_	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00536 Reg. Dist. No. 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) - b COUNTY Balto.City c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? 1705 N. Patterson Park Ave. YES NO 1958 January 8. 9. AGE (In years loss birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Days 12. CITIZEN OF WHAT COUNTRY? U.S.A. Address Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH Years -Years. C. B. S. SESSOC. WILL CONTRIBUTION CONTRIBUTIONS CONTRIBUTION OF THE PROPERTY WITH PART 1(0) 19. WAS AUTOPSY WITH PART 1(0) 19. WAS AUTOPSY DESCRIPTION OF THE PROPERTY OF THE PERFORMED? YES NO TO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) (County) (Stote) to January 8, 1958 that I last saw the deceased . and that death accurred at 10:05A.M. from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital (State) 24a. REC'D BY REGISTRAR

0

VS A15 (4)

OBVIESED V. 8. V. V. S. V. V. S. V. UAENUA

1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 $()()54()$
4 5% .	541 CERTIFICATE OF DEATH  Reg. Dist. No. 75
1. Page	1. PLACE OF DEATH o. COUNTY O. STATE O. COUNTY
death mera d be	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)  RURAL and give nearest lown)  IN NCH ESFEN  C. LENGTH OF STAY IN 16  C. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lown)  IN NCH ESFEN  C. TY OR TOWN (If outside carporate limits, write RURAL and give nearest lown)
s affer 2 shaul	d. NAME OF HOSPITAL (If not in hospital, give street oddress)  OR INSTITUTION  OR INSTITUTION  A STREET ADDRESS  OR INSTITUTION  ON A FARM?  YES   NOW
24 hour	3 NAME OF First Middle Lost 4. DATE Month Day Year DECEASED OF Month Day Year
rely Post	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years IF WINDER 1 YEAR IF UNDER 24 HRS.
country to base of the country of th	100 USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?
be exe	13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME
g physicia remave co 72 havrs al	LSORC JULICK SAVILLE CLETCH  15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT  Address
offing page ren	(Yes, no or unknown) (If yes, give wor or dotes of service) NONE MISS Gertrude Walker, HANOUCH PA.  [18. CAUSE OF DEATH [Enter only one couse per line for y). (b), and (c).]
the dec e atten en ple int with	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POPIC MYOCAY diff.
s that if the lift. The my eve	Conditions, if ony, which) BY Kinio-Sclentic Cardiolascular Diseases
require on signer sit perr nd in c	gove rise to immediate cause (a), stating the under-lying couse lost.
physicie os beer ial-tran	PAIT II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \( \subseteq \text{NO.5} \)
IAN: The ending ficate has bur remained.	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Port II af item 18.)  OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)
HYSIC I ar ath its certi use as matian,	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work of w
DING Phaspita After It ned for ial, cre	21. I certify that I attended the deceased from Sipt 3 , 1951, to JAN 19 , 1956, that I last saw the deceased
ATTEN by the CTOR: detact to bur	alive on A. M., from the causes and on the date stated above.  ADDRESS (Street, city or town, state)  DATE SIGNED
NL OR fained L DIXE	SIGNATURE SIGNATURE SIGNATURE SIGNATURE M.D. Horupolind Mel 1-14-58
OSPITA Per registre	NAME PYPO) / OS CP TO US A PI TO THE THE THE POP (22 NAME OF CEMETERY OF CREMATORY (City, town) or copyris) / ASLOW)
may 1 TO FUY page The re	23 FUNDERAL DIRECTOR'S SIGNAYURE ADDRESS (240, REC') BY REGISTRAR 246, REGISTRAR'S SIGNATURE
VS A1S (4) 15M 9/55	HROUNCE Bucher Hanour Ja DATE Haw 21 Mes hes Donne
	JAN 2 3 '58 Une sauch

BUREAU V. S.

638F - 83 - MAI

BECEIVEL

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00537

CEDTIEICATE OF DEATH

542 CERTIFICA				ATE OF DEAT	П		Reg. Dis	st. No.				
1.	PLACE OF DEATH a. COUNTY Car	roll		MAR	YLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City 3:						
	b. CITY OR TOWN (If RURAL and give nea Sykesvill	irest tawn)	]	c. LENGTH OF STATE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give rearest town)  Baltimre						`
	d. NAME OF HOSPITA OR INSTITUTION Spring	L (If not in hospital, state	iva street o	spital.							IS RESID ON A F YES	ARM2
	NAME OF DECEASED (Type or print)	Harr	7	W11bu	r	lost Wallace	4. DATE OF DEATH	Mor <b>Ja</b> n		20 20	Ye 19	58
5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   WIDOWED   DIVORCED		ED 🔲	B. DATE OF BIRTH  3-13-83		9. AGE (In years lost birthday) 74 yrs.	Months	Days	Hours	Min			
10c. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  Shippard labor  12. CITIZEN OF WI  Shippard labor  12. CITIZEN OF WI  S.A.							OUNTRY?					
]3.	FATHER'S NAME	rew Jacks	es Lie	17.00		14. MOTHER'S MAIDEN	NAME ett Go:	nd an				
15	WAS DECEASED EVER			SOCIAL SECURITY NO	2 17 11	NFORMANT	3 CC (CO)	Add				
14.	n, no, or unknown) (II	i yes, give war or dates of t	arvice) Q/	17-09-291	油出	ospital recon	rds	700	1033			
	18. CAUSE OF DEAT PART 1. DEAT	H WAS CAUSED BY:	Arte	rioscleroi	tie N	eart Disease					VAL BETY TAND D TS	
	420.0	DUE TO	Gene	ralized Ar	rteri	osclerosis				yea	rs	
	Conditions, if any	y, which ) (b	1									
	couse (a), stating the											
CERTIFICATION		R SIGNIFICANT CON	PHONSE C	ONTRIBUTING TO DE	ter1	NOT RELATED TO THE TERM	ith Ps	condition gi	EN IN PART	r I(o) 19.	WAS AL	HTOPSY WED7 NO IX
	200. ACCIDENT WAS OR CONTRIBUTING E (IF EITHER, NOTIFY A	UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	206. DESC	RIBE HOW INJURY (	OCCURRE	2. (Enter nature of injury in	Part I ar Par	t II of item 18.)				
MEDICAL	20c. TIME OF INJURY Hour 6. jt. p. m.	Manth, Day, Ye	20d, IN While of work	BURY OCCURRED Not while of work	20e. PL/ Foo	CE OF INJURY (Home, fari tory, street, affice bldg., et	m, 20f. (City	or town)	(0	County)		(Stole)
	21. I certify the	it 1 attended the	decease	ed from 8-15		, 1956_, to 1-	-20	19.58	.,that	ast saw	the d	eceased
l	alive on 1-	20_	12.58	8 , and tha	t death	occurred at 10	AM, from	n the causes o				
	ACTUAL SIGNATURE	nestri	d	il Can	upa	Springfie	ADDRESS IS	treet, city or town.	state)		DAT	e signed
	PHYSICIAN'S AR	ustin del	Camp	o M.D.		Sykesvil	le, Ma	ryland.				
220	REMOVAL (Specify)		-58	22c. NAME OF CEN	,	crematory	77	TION (City, lown,		MI	(Slate)	
23.	FUNERAL DIRECTOR'S	SIGNATURE	ı	ADDRESS			D BY REGIST			NATURE		

150 E FORT AND DATE JAN 2 3 '58

VS A15 (4) 15M 9/55

Mc Colly Funcial Nomes

2 V UABAUR

DECEINE

1	MARYLAND STATE DEPARTMENT OF F	EALTH—BALTIMORE, 18							
FOR STATE	MEDICAL EXAMINER'S CERTII								
HEALTH DEPT.	343	Reg. Dist. No.							
11 2 2 2 9	" a. COUNTY	IDENCE (Where deceased lived, If institution: Residence before admission)  b. COUNTY							
1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		laryland Washington							
5 F T	and give negrest town)	TOWN (If outside corporate limits, write RURAL and give nearest town)							
d of		agerstown / 2 ma							
of de de	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Springfield State Hospital  33	ON A FARMY							
in on the									
Funda de la constanta de la co	DECEASED	OF - /							
The fler	(Type or print)  James  William  WRICHT  5. SEX  6. COLOR OR RACE  7. MARRIED  NEVER MARRIED  B DATE OF BIRTH	odiladi'y							
A C C C C C C C C C C C C C C C C C C C	Male White WIDOWED DIVORCED July 4.	1997   Interest   Months   Days   Hours   Min.							
hour hour									
72 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 8 RTHPL during most of working life, even if retired)  Laborer  West	Virginia U.S.A.							
F-1.1.		MAIDEN NAME							
P. P. S.	Tananh Wadaha	ry Hoffmaster							
eve ile	15. WAS DECEASED EYER IN U. S. ARMED FORCES? [16. SOCIAL SECURITY NO. ] 17. INFORMANT	Addren							
1. F.	1 (Yes, ng. ex unknown) 1 (If yes, give war or dates of tervice)	gfield Hospital Records							
100 年記	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c) ]	Interval between							
ond ond	a S days.								
d in a second	FART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  4-20 / DUE TO								
Piro Piro	Conditions, if ony, which) (b) Infarctive myocardial fi	brosis l yr. plus							
a de la companya de l	gave rise to immediate cause								
o b	(c), staling the underlying (c) Arteriosclerotic cardiovascular disease Years								
fre shared and and and and and and and and and an	C.B.S. assoc. with circ. dist., with cerebral arte	THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY							
of E		YES NO							
d	Describe How Injury Occurred (Enter noture of in Unknown.	jury in Port I ar Part I) of item 16 )							
F M Culd									
she she	20c, TIME OF INJURY Month, Doy, Yeor Haur a. m. 12/30/ 157 While Not while of work of work Not work Nospital	bido., etc.}							
Pe 3		Sykesville Carroll Md							
Pog P	21. I certify that I took charge of the remains described above, held an	Autopsy 🔼, Inspection 🔼, Inquiry 🔼, and m my							
OR Sent	opinion death resulted from: Natural couses , Accident , Suicide	, Homicide [], Undetermined manner []							
FCT of a	DATE SIGNED								
Ferring Correction of the Corr	SIGNATURE	NEDICAL EXAMINER							
A Pe	Evaluation -	NT MEDICAL EXAMINER 1/7/58							
5 and p	NAME TYPE: James T. Marsh, M.D. DEPUTY  220. BURIAL CREMATION, 226 DATE THEREOF   22c. NAME OF CEMETERY OF CREMATORY	MEDICAL EXAMINER							
E SAN E	PEMOVAL (Specify)	22d LOCATION (City, lown, or county) (Sinte)							
F . 5	15 Literal 1-4-3 8 Test Mavel Connetc. 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS GOT DOWN ASSET	Y ITA GENSIEUR 240. RECISTRAR SIGNATURE							
MS A15ME	Rest Have We in reveal Charles I tager in	DATE JAN 1 4 '58 Clure educa							
\$M 2757		VAIL .							
	R. m marting V Pres.								

## DILLEAU V. &

MI VOLUE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

HTASO RO STADRITATO

BUREAU V. &

SEEL IS MAL

BECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00541

e. IS RESIDENCE

Day

Days

ON A FARM?

YES NO K

Year

19

INTERVAL BETWEEN

ONSET AND DEATH

YES NO 17

(State)

(Stole)

58

Landon will go the first hard BUREAU V. S. the same that the same way SZEL SI NAL